State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IRENE ORDI 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HANOVER ANNE ARUNA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F 9 0 Months Days Hours Min. **Director** Usual Residence of Decedent 19c. City, Town or Location 10a. State 10d. Inside City Limits Director notified 28a-f 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? ō must be Funeral 23a USF 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc Completed by 1 Never Married 2 Married 9 Specify: BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 KNo Specify: "natural" 3 Widowed 4 ☐ Divorced is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ ThomAS IMMS 19a. Informant's Name/Relationship (Type, Print) VEPAEW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MARCKS 4 Donation 5 Other (Specify) Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on geth line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Mo 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h Yes 25. Was case referred to medical examiner? 1 Yes 2 N Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

31. Date filed (Month, Day, Year)

2 1 2012

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SIL Month Physician/ Year ,55A M nae 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE HEALTH CENTER CLINTON PRINCE GEORGE'S 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min 1 □XM 2 □ F 66 Yrs. Director 578 - 58 - 5366 WASHINGTON 1945 Usual Residence of Decedent shov 10b. County 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC WASHINGTON 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country?
UNITED STATES 2102 SAVANNAH TERR. SE #K Funeral 20020 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 - Widowed 4 - Divorced Completed BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th PRINTER PRIVATE permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VINCENT BROWN VIVIAN BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL BROWN JR. 2102 SAVANNAH TERR., SE #K WASH.,DC 20020 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREM. 5/8/2012 BELTSVILLE, CAPITOL MORTUARY 21. Sign there of Funeral S Lice 22. Name and Address of Facility 1425 MARYLAND AVE NE WASH., 20002 23a. Part 1. Enter the dise s s, or complications that caused the death. D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner oronary if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

E Loneral Director: After this certificate has been signed by the attending physicial Funeral in by the funeral director, page 2 should be detached for use as the buil whete filled in by the funeral director, page 2 should be detached for use as the buil Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes _2 🖬 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural 2 \square No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2

To the I

complete only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 0053337 30. Name and address of persork who completed cause of death (Item 23a) (Type, Print) Pineview lane 106

State Registrar 32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) \$50 pm Wilbur Physician/ Edward Crouse Medical 4c. County of Death 4a. Facility Name (if not institution, give street, 4b. City Town, or Location of Death Examiner Limore O if Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Social Security Number Funeral 1 🛛 M 2 🗆 F 81 Months 217-26-9142 Sept 1930 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e ~~ any injury or other traumatic event, the Marianian or other traumatic event. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Manchester MD Carroll 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21102 USA Funeral 4526 Hanover Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married ò Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Ingersol-Rand Elementary/Seconday (0-12) College (1-4 or 5+) service manager Be 18. Mother's Name (First, Middle, Maiden Surname)
Genevieve Adams 17. Father's Name (First, Middle, Last) Samuel T. Crouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4526 Hanover Pike, Manchester, MD 21102 19a. Informant's Name/Relationship (Type, Print) Kathleen Crouse (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Marriottsville, MD 4 Donation 5 Other (Specify) Crest Lawn Memorial 5-19-12 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dage Saight Herber P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mesotheliona Physician/ MIKNOWN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Litter or userying Cause (Disease or linjury that initiated events burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Yes 2 No as been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown artery 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA |은 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Suicid 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D41843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 eman Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Baltimor Year If Under 24 Hrs. If Under Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 D F Month, Day, Min. Director ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore 1 1 Yee 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21210)attur 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. A r Force 1 Yes 2 NA Specify. Specify: "natural", Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me /Seconday (0-12) Flementan College (1-4 or 5+) olog 0 Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ၉ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code ratare Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State 20c ery, crematory or othe □ Surial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Familie 22. Name and Add 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition. Do not enter the mode of dying Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 Fetal death Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the detached 9 Unknown P.O. | s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ Division of Vital Records, 1 Yes 2 No 3 Probably Completed 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion death? has page 2 autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 2 No 1 Yes Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 18, 2012 30/Name and address of person w who completed cause of death (Item 23a) (Type, Print) Loch Raven Blud 00 Baltimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUDITH DICKSON Month 5 G. 2012 9:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson Examiner 4c. County of Death Baltimore Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11/19/1944 Months Days Hours Director 1 □м 2 🖾 ғ 200-34-5652 67 Yrs Pennsylvania Usual Residence of Decede th end Mental Hygiene. 27 is merked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examiner must be notified at permit. Pege 1 end 2 should be filed within 72 hours effer deeth with the Meryland Department of Heelth end Mental Hyglene. Importent: If item 27 is merked other then "neture!" eny hiury or other treumetic events. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** MD Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1405 Northgate Road 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Dietitian medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gardner Richard Mary Ann Felleisen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Northgate Road; Baltimore, MD 21218 Darrall J. Dickson / husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc | 05/21/2012 | Catonsville, MD 22. Name and Address of Facility The Johnson Funeral Home, P.A. 21. Signature of Euneral Service Licensee MOO217 8521 Loch Raven Blvd.: Towson, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ - Nea Canco disease or condition resulting in death) remons Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ettending physicien and for use es the buriel-transit or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? trom bo embolic Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certificate: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Autonomic within 24 hours efter deeth.

To the Funerel Director: Afte completely filled in by the fun Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUES 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:20 P M rreeman ZOIT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Golden Living Center Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min. **Director** 1**XX**M 2 □ F 215-14-4013 2/11/1922 Usual Residence of Decedent 90 MD or 28a-f show notified at the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2X No MD Carrol1 Finksburg 10e. Street and Number ō 10f. Zip Code , or items 23a or aminer must be n 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 3278 Louisville Rd. 21048 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1941 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) h and Mental Hygien 7 is marked other tl 4 Accountant C.R. Daniels Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Richard Edward Freeman, Sr. Annie L. Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie V. Freeman/Wife 3278 Louisville Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park 5/23/2012 Woodlawn, MD 21. Signature of Funeral Service 22Burrier Ween'y Funeral Home & Crematory, P.A. and 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} emention vere disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) been signed by the a should be detached Yes 2 No g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate I 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 - No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hot To the Fune completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52435 2012 2(30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner CHACKO 31. Date filed (Month, Day, Year) strar's Signature

★ DHMH 17 Rev 06-2011

State

Registrar

MAY 2 1 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 May 14, 8:15 P^{M} Ferdinand W. Gilley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore Frederick Villa Nursing Home If Under 1 Year If Under: 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 92 Days Months Hours Min 1**XX**M 2 □ 16777774979 Maryland 218-01-1440 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6610 Kilmarnoch Drive United States 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. White 3XXWidowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Composition Specialist Printing 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ferdinand Clayborne Latrobe Gilley Sophia Willson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Gilley - Nephew 6610 Kilmarnoch Drive Catonsville, Maryland 21228 Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 $\fill \fill \f$ cemetery, crematory or other place) orraine Park Cemetery 05/19/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee and Address of Facility J. Weber Funeral Homes P.A. <u>Edmondson Avenue Baltimore, Mar</u>yland 21229 3a. Part 1. Enter the disease or cor sheck, or heart failure. List only olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Eare disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has pertorm 1 ☐ Yes 2 🔀No 1 Yes 2 No filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hor To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print)

State Registrar Day, Year,

1 8 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:40 PM CLIFFORD LAWRENCE IBEH 2012 a Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** Regional Prince George's 1_dure! Hospita Laure 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 AM 2 □ F Hours JUNE 14 ^{ea}195<u>3</u> 579-11-1656 58 NIGERIA Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland be notified at Director 1 X Yes 2 □ No PRINCE GEORGE'S MD BELTSVILLE 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3713 GREEN ASH COURT 20705 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married Yes Yes, Give Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Completed Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 5+ REGISTERED NURSE PRIVATE Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ INNOCENT IBEH JOSEPHINE EGOJI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREEN ASH COURT BELTSVILLE, MARYLAND 20705 SYBIL IBEH/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State FAMILY PLOT 6/13/2012 AHIAZU MBAISE, NIGERIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. This the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hypoxid Medical r as a consequence of) **Examiner** Respirator Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury -drdiogenic burial-tran that initiated events or Attending Physician: The law requires that the death certificate be exec resulting in death) Last attending physician for use as the buria Physician/Medical Acute Infarction Myocardia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

16

aurel Regional Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dusen Road

7300

Ldurel

Van

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mathew Lshmae 1710 PM (a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Hospital of Ballemore Baltemore Cely NIA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 1 M 2 F rividad show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 -airmount Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Shrael, Patric 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Serraneau ဂ Sheila Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shmaeu south more, MID 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Boutina 4 Donation 5 Other (Specify) f Funeral Service Licens Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ eft thamic and gue to (or as a consequence of): thamic disease or condition resulting in death) Medical Examiner Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical Records, P.O. Box 68760 as the k IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be performed? Yes 2 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1
Yes 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) apri RES-000 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinsi TAMNA Homitel o 32. Registra 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Z Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ma 2012 BESSIE ANN JONES Medical 4a. Facility Name (if not institution, give street and number, 4b, City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) 245-58-3452 1 □ M 2 💢 F Director 72 Yrs SEPT. 18 1939 NORTH CAROLINA 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director notified 1X Yes 2 □ No MD PRINCE GEORGE'S HYATTSVILLE 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a USA 20784 7515 BUCHANAN STREET 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 X Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the PRIVATE 6th HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ျ LANNIE MITCHELL WILLIAM AMBROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 7515 BUCHANAN STREET HYATTSVILLE, MARYLAND 20784 JONES/DGT. LESA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 5/25/2012 LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. . Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death SLEEDING Ph.sician/ disease or condition Medical resulting in death) Due to (or Examiner DISSECTING ABDOMINAL ADRICC ANEURYSM if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Physician/Medical Examine ATHEROSCIEROSTS burial-transi attending physician and Due to (or as a c PERTENSION P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Hospital or Attending Physician; The law requires that the death Day Pregnant at time of death 5 Other (specify) Month Year been signed by the a should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: ဂ္ 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certifie MDD 39795 05/18/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wilton Nedd, m.D. illo Varnum St. NE, Sixi te 217 De Paul Bidg., Washington De Carry

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a, 25, 27, 28a-f. per me, 2938, 4-9-13 sm.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 VIVIAN JACKSON May 6:25 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number 6 Sex if Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Days Director 162-34-1514 1 □ M 2 🛣 F VA May 4, 1941 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 1 Yes 2 No Prince Georges Fort Washington 10e. Street and Number Ь 10g. Citizen of What Country? must be Funeral with 23a 8100 Pates Place 20744 USA an "natural", or items Medical Examiner mu within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Yes 2 No 1 Never Married 2 Married Black, White, etc. <u>6</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 'natural", 3 XWidowed 4 Divorced Completed Specify **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 10th Daycare Provider Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or ဂ Mary Womack traumatic Jesse Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s of Health are: If item 27 i 8100 Pates Place Fort Washington, MD 20744 Mozella Womack-Sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State ò permit. Page Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5-22-2012 Alexandria, VA 21. Signature of Funeral Service Licenses Marshalf Marten Funeral Home of Maryland sclar 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Temur Fracture with Complications

Ventral Tachycardia

a. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examine Sepsis Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or): CERTIFICATION APPROVED BY MEDICAL EXAMINER Exami Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): burialattending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Records, Hospital or Attending Physician; The law requires End Stage Renal Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been 24b. Were autopsy findings available prior to completion of cause of death? Hypertension, Diabetes Mellitus, Dislipidemia 24a. Was an has autopsy performed Yes 2 X No 2 No 1 Yes Division of Vital director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 X Yes 2 X N 욘 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? s after death. subject tripped and fell the f 2 X Accident 2 K No Investigation 10:30 A.M 3-31-2012 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State 8100 Pats Place 4 Homicide determined Hill 24 hours a Fort Washington, MD. Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 2 [within 2 To the only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D70630 05/21/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Roy, Ashok 7503 Surratts Rd., Clinton, MD 20735 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 5,29 AM onnson non Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** rating 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Country 32 Month Day 1 M 2 D F Days Months Min. 71 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Baltimore mi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21211 USA death 12. Was Decedent Ever in U.S. Armer Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced William Johnson, ST 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hundler ath Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility Signatur Funeral Service Licens P. March Fly 270 Fredhilton Pless Ballo mb 21229 23a. Part 1/Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheros clerotic Disease Physician/ Cerebrovascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 L 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Mnknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred 28c, Injury at (Month, Day, Year) injury 1,XNatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nursa Practioner To the best of my knowledge, death 3. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Taymond Miller mo D47683 5/16/12

DHMH 17 Rev 7/2009

State Registrar OWINGS

Mills MA 21117

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box

1525

32. Registrar's Signatur

PO

Raymord Miller

31. Dan lied (Month, Day, Year)

12-03803 Jung-Sook Kim Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

Jung-Sook Kim	1- For State	State of Mar		tment of Hea ificate of Dea	aith and Mental ath		201	2 1601
Physician	Registrar 1. Decedent's Name (First	st. Middle,Last)	OGIL			Reg. 2. Date of Death		3. Time of Death
/Physician Mمنامal Examiner	Juna	Sonk 1	Kim			Month [May 18, 201		1355 hrs
()	4a. Facility Name (if not i				, Town, or Location of De	eath	4c. County of Death Anne Arundel	
		nington Medical Ce			n Burnie	Hrs IR Date of Birth	(MM/DD/YYYY) 9. Birt	holace (State or
Funeral	5. Social Security Number	-	7. Age (In yrs. las	17 Mo		Min.		n South
Director	220-76-21		f	/ Yrs.		March	12,17411_	KOTCA
any	Usual Residence of Dece 10a. State 10b.	County	1	Town or Location	.,			10d. Inside City Limits
*	MD	A.H.	- 1 Ci	OUNS	1110			1 Yes 2 No
the Maryland or 28a-f shu tified at once Director	10e. Street and Number		11. /	10f.	Zip Code		. Citizen of What Cour	
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r death with mr items 23 must be no	11. Marital Status 1 Never Married		Decedent Ever in U.S ed Forces?	s. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.	Lair Indian, Diaos,
er deal	3 Widowed 4		es 2 No	1 Yes	2 No specify:		Specify: A	Sian
tural" tural	15 Decedent's Educati	ion (Specify only highest		16a. Decedent's Us	ual Occupation (Give kind working life. DO NOT use		16b. Kind of Business/I	ndustry
72 ho 12 ho 11 Ex	Elementary/Secondar	y (0-12) Colle	ge (1-4 or 5+)	t /	WORKING IIIE. DO 1401 asc	o rourou,		0060
5-0036 ed within 72 hour lygiene. the Medical Exar Completed	12		,	How	18 Mother's N	lame (First, Middle, M	aiden Surname)	ESTIC _
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked atter than "natural", c event, the Medical Examiner To Be Completed by	17. Father's Name (First	, Middle, Last)	1.1		*	ng Yu	Yu	
2121: ould be fill d Mental I s marked fit event,	19a. Informa ,s Name/F	Relationship (Type, Print	1	19b. Mailing Addr	ess (Street and Numbe	r or al Route Numb		, Zip Code)
MD 2 d 2 shoul lth and N n 27 is n numatic	Ki Hwa	n Kim		1032	eneral	Highwa	20c. Location - City or	SUITE, MU
ore, MD 21215-003 so I and 2 should be filed with of Health and Mental Hygiene. If item 27 is marked rither ti ther traumatic event, the Mee To Be Com	20a. Method of Dispositi	ion Cremation 3 Remo		Place of Disposition (rematory or other place		Date	206. Ebcation - City of	Town, state
Pages nent of ant: 1	4 Donation 5	Other Specify	/M	eadour	idge C	0 12412012	Cotunik	ya, No
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggene. Important: If item 27 is marked ruter than "matural", ar items 23a or 28a-f ab injury or ruther traumantic event, the Medical Examiner must be notified at once injury or ruther traumantic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	21. Sign dure of Funera	Service Licenses	1 Ch	22. Name	and Address of Facility	Howell	FUNER	al Home
	23a, Part I. Enter the dis	sease, or complications t	that caused the death.	Do not enter the mo	de of dying, such as card	liac or respiratory arre	st, shock, or heart	proximate Interval Between Onset and
Physician (Medical)	failure. List only or	ne cause on each line.			Intoxication			Death
≟xaminer	Immediate Cause (Fina or condition resulting in		r as a consequence of					
	Sequentially list condition		or as a consequence of	f)·				1
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certificate certificate sading phy	23b. Was decedent prec past 12 months?	gnant in the 1	Live birth Pregnant at time of de	2 Fetal de		regnancy	Month	Day Year
he death certificate the death certificate to you the attending phy ched for use as the tending the desire of the tending the desire of the tending the tending the tending the tending the tending the tending tending the tending tending the tending tendin	1 Yes 2 ✔ No 9	o □	Unknown	5 Other	Specify)			
		int conditions contribu	iting to death but not r	esulting in the under	lying cause given in Part		bacco use contribute to	
P.O. es that the signed by be detach								obably 4 Unknown
rds, requirements been should						24a. Was autop	sy prior to	utopsy findings available completion of cause of
Reco The law icate has						perfor 1 ✓ Yes		
,= ·	25. Was case referred examiner?				26.Place of Death (C			
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should be	1 ✓ Yes 2	No Hospital:	i inpatient 2	ER/Outpatient 3			Residence 6 Oth	эr:
		Ponding	Date of Injury (Month, Day, Year)		1 Yes 2 X	subject	ingested	drug and
Siol Aften r death ector: by the	2 Accident	Investigation 10	d 5-18-12 e. Place of Injury - At h	fd 1:07 p nome, farm, street, fa	ctory, office building, etc.	Hanged 28f. Location (\$	Street and Number or F	Rural Route Number, City
Division pital or Attendi ours after death. filled in by the fi	1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	Could not be determined (S)	pecify) Four	nd:Reside	nce	Odenton	,MD.	en Grove Ct.
		ertifying Physician: To t	the best of my knowler	dge death occurred	at the time, date and place	e, and due to the caus	e(s) and manner as sta	ated.
To the Has within 24 h Ta the Fu	one) Me		basis of examination anner stated.	and/or investigation,		urred at the time, date	29d. Date signed (M	
Far a	29b. Signature and title		1		29c. License number O.C.M.E.		May 19, 2012	one, buy, rour
1	(lax	Lokelle	<i>I</i>	- 225)	O.O.IVI.L.		,	
4	30. Name and address Laron Locke N	s of person who complete	ed cause of death (Iter edical Examiner	m∠₃a) 900 W. Baltir	nore Street, Baltim	ore, MD 21223		
Sta	O. S. J. Stanton at	Day Year)	32. Registrar's Signa	ture ,				
Registr	ALAV A		une B.	BAKE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g928 6-8-12 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Kenneth Krystofiak 17:14 PM Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 8 Date of Birth (Month, Day, Year) 0 4 / 1 4 / 1 9 4 8 9. Birthplace (State or Foreign If Unde **Funeral** Months Hours Maryland 64 **Director** 218-46-9246 1 XM 2 □ F Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1XXYes 2 □ No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21231 United States 325 S. Register Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 Yes 2XXVI Maryland 21215-0036 1 ☐ Yes XXNo Specify White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Home Improvement Carpenter permit, Page 1 and 2 should be filed wit Department of Health and Mental Hygles Important: If item 27 is marked other 1 any injury or other traumatic event, the <u>once.</u> 9 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) 2 Rita Kowaleski Michael Joseph Krystofiak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7024 Conley Street Baltimore, Maryland 21224 Joann Oliaccio - Sister altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 05/18/12 Glen Burnie, Maryland 4 Donation 5 Other (Specify 21. Signature of Funeral Service Li David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, MD 2123 Part 1. Enter the disease, or complication sheek, or heart failure. List only one cau ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate e on each line Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate has page 2 Yes 2 1 ☐ Yes 2 ☐ No funeral director. 26. Place of Death (Check only one) 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 2 Accident
3 Suic 1 Natural 5 Pending work? 2 No Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2

To the I

comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD lress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 1800 Orleans Street, Bouthmore enniter ar Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dorothy Physician/ Kappau 2012 15: 45 PM Medical City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and number) **Examiner** Maryland Itimore redical center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 05/28/1925 219-18-1031 Director 1 □ M 2 💢 F 86 Massachusetts items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director Maryland Elkridge 1 Yes 2 No Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6044 Augustine Avenue 21075 United States 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 5 1 Never Married 2 Married þ altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White ed other than "natural", event, the Medical Exar 3 🕅 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Accounting Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೨ John F. Weaver Margaret G. Connors traumatic . Page 1 and 2 should be tment of Health and Mer tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Neville / Daughter 6044 Augustine Avenue Elkridge, Maryland 21075 other 1 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Crownsville Veteran 05/21/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility David J. Weber Funeral Homes PA 5311 Edmondson Avenue, Paltimore Maryland 21229 23a. Part 1. Enter the disease, occumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ver 1-ens o (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Dther (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an cate has t autopsy within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 1 Dopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mapner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Date of injury 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Baltimore MD 2120 State Registrar

DHMH 17 Rev 06-2011

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6

errick L. Lawson	State of Maryland / Department of Health and Menta 1-For State Certificate of Death	l Hygiene	2012 60						
Physician/	Decedent's Name (First, Middle,Last)	2. Date of Deat	.g. 110.						
Medical Examine	Dellick E. Lawson	Month May 13, 20	Day Year						
)	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D University Hospital Baltimore	eath	4c. County of Death						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4Hrs. 8 Date of Birt	NA th(MM/DD/YYYY) 9. Birthplace (State or						
Director	216-92-2606 1XM 2 F 33 Yrs. Months Days Hours	Min. 08-09-78 Foreign Country) M							
b	Usual Residence of Decedent		TID						
OW Any	10a. State 10b. County 10c. City, Town or Location NA Baltimore		10d. Inside City Limits						
the Maryland n or 28a-f show tified at once. Director	10e. Street and Number 10f, Zip Code		1 Yes 2 No						
th the Maryland 23a or 28a-f she notified at once 31 Director	319 S. Parrish Street 21223	110	og. Citizen of What Country? USA						
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin?	(Specify Yes or No-							
or death with	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc. African						
irs after in in ince	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind)		Specify: American						
5-0036 led within 72 hour lygiene, other than "uatu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DD NDT use	retired)	16b. Kind of Business/Industry						
5-0036 led within 72 Hygiene. other than the Medical	10th Grade NA Janitorial		Loving Touch						
21215-0036 wild be filed within 7 Mental Hygiene. marked other than e event, the Medica. FO Be Comple	17. Father's Name (First, Middle, Last) 18.Mother's N	ame (First, Middle, M	laidea Surname) Liverman						
212 hould be and Ments is mark tic even	Larry V. Lawson Line 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	da or Rural Route Numb	Liberman ber, City or Town, State, Zip Code) 21216						
MD d 2 sho d 2 sho lth and n 27 is numeric	Larry Lawson-Brother 1/03 N. Smallwood	Street Bal	timore Maryland						
# ### ## # # # # # # # # # # # # # # #	1 XXBurial 2 Cremation 3 Removal from State crematory or other place)	Date	20c Location - City or Town State						
Baltimore, permit. Pages I au Department of Her Important: If ite mjury or other tr	4 Donation 5 Other Specify: New Cathedral Cem. Of King Mem. Park		Randallstown, Baltimore, MD						
Baltimo permit. Page: Department o Important: injury or oth	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Wylie Fur	neral Home P.A.						
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardia	ac or respiratory arres	Imore, Maryland 21217 st, shock, or heart Approximate Interval						
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot Wounds		Between Dnset and Death						
ANT PARTY	or condition resulting in death) Due to (or as a consequence of):								
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
and transit	d								
to, e be executed ysician and burial - transit	UNPENDED #28becFH, G928, 8927, 25724-12 vt								
Box 6876(he death certificate the attending phy- hed for use as the b hysician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery						
he death certificate the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Inknown 4 Pregnant at time of death 5 Other (Specify)	griancy	Month Day Year						
that the de by the detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 Did tob							
s, P.O. ires that the signed by a libe detached by P.			23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
Records, The law require ficate has been significate has been significant has been significa		24a. Was an	24b. Were autopsy findings available						
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ital Reciein: The certificate rector, page	25. Was case referred to medical examiner? 26.Place of Death (Cher		No 1 Yes 2 No						
of Vital 1g Physician: ther this certi neral director 1: To Be	1 ✓ Yes 2 No Constitute 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nur		esidence 6 Other:						
ion of tending Pi eath. for: After the funera	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury 1640 hrs 1 Yes 2 No	28d. Describe hor Subject shot	w injury occurred						
Division rs after death. al Director: A led in by the fu	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f, Location (Str	eet and Number or Rural Route Number, City						
Division control of the control of t	or Town, State) 4 W Homicide determined (Specify) Local Street (Specify) Local Street								
	29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause(s	s) and manner as stated.						
S S S S S S	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 296. Signature and title of certifier 29c. License number								
	Chaloman O.C.M.E.	1.	29d. Date signed (Month, Day, Year) May 14, 2012						
	00. Name and address of person who completed cause of death (Item 23a)		, ,,=						
	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	, MD 21223							
State Registrar	11. Date filed (Month, Day, Year) 32. Registrar's Signature								

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 12-03682 Lacey Lamb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

acey Lamb		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2 2	1601							
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Time of Death 2245 hrs							
-		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore)							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplate (In yrs. last birthday)	ace (State or							
Director		213-37-1548 1 M 2 F 19 Yrs. Months Days Hours Min. July 19, 1992 Country	M MD							
any			d. Inside City Limits							
Maryland 28a-f show 1 at once.	tor	5 HD NA Bathmore 106. Street and Number 109. Citizen of What Country?	Yes 2 No							
the Mar a nr 28a	Director									
ath with items 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.	Indian, Black,							
after de ral", nr	by Fu	Specify: Spe	rck							
72 hours			^							
0036 within ' giene. her tha	Completed	17. Father's Name (First, Middle, Last) LandScape 18. Mother's Name (First, Middle, Maiden Surname)	ourg							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Lace E. Lamb, Jr Terri Davis	Ü							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygiens Important: If litem 7 is marked other than "natural", ur items 23a nr 28a-f sho injury or ather traumatic event, the Medical Examiner must be notified at once.	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 4213 W. 11Shire Ave, Bathnia	Code)							
ore, N is 1 and of Health If item		20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, Date 20c. Location - City or Tow crematory or other place)								
Baltimore, permit. Pages I as Department of He Important: If ite injury or nther it		4 Donation 5 Other Specify: Metro 5/2012 Balth M	10Ze, MID							
Ba Perm Deps Imp	,	Land frame Ay. 3331 Brehms ku, Battimon								
Physician // Medical		failure. List only one cause on each line.	pproximate Interval letween Onset and Death							
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Division of Vital Records, P.O. Box 68760, In the Bopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the Funeral Directuer. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical E	d. UNPENDED AMENDED								
760, icate be ex physician the burial	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 4 Live birth 25c. Total death 25c. If yes a live birth 25c. If yes a live birth 25c. If yes, outcome of pregnancy 25c. If yes, outcome of yes, outcom								
Box 6876 death certificat he attending phi of for use as the	ä	2 So. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify)	Year							
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on of anding Pt tth. r: After he funeral										
Division tal or Attendi rs after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Ror Town, State)	(Street and Number or Rural Route Number, City							
Div Ta the Bospital or within 24 hours after Ta the Funeral Dil completely filled in										
Tn the Bo within 24 h Tn the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.								
	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D May 14, 2012	Jay, Year)							
100		30. Name and address of person who completed cause of death (Item 23a)								
<i>U</i>	ate	Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registrar's Street, Baltimore Street, Baltimore, MD 21223								
Regis	trar	31. Date filed (Month Day Year) 32. Registrar's State								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MZL Physician/ Month A 810 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Northwest Hospital Center 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Feb 5 1933 Director 213-30-2637 1 □ M 2**X** F 79 Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nardment of Health and Mental Hygiene. sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Randallstown Baltimore 1 Tes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21133 USA 4407 Chapel Dale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white If Yes, Give Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) office manager grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fannie Shifflett Gilbert Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Fields (daughter) 12520 Indian Hill Dr., Sykesville, MD 21784 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or or once. 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 5-21-12 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Saught s Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine nding physician and use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ate has been signed by the atten page 2 should be detached for u in the past 12 month Pregnant at time of death Month Dav Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 2 **N**O 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗌 No 1 🗌 Yes Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Hospital or Attending Physi 24 hours after death. Funeral Director, After this o 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: L latural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a
To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Court hand like esuille

Registrar DHMH 17 Rev 06-2011 persor who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

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Please Type or Print in Black Indelible Ink Fnsure All Copies Are Legible.

AMEND ITEM#5perFH, 6927,5/30/2012, ws

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle_Last) 2 Date of Death Physician/ Hayden Perkey Month MRV 6:454 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Hospital Randallstown Baltimore 8. Date of Birth (Month, Day, Year) 28, 1932 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 T.TT Funeral 7. Age (In vrs. last birthday) Hours 232-52-1699 Director 1 X M 2 □ F 79 show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location must be notified at Director 10d. Inside City Limits MD Carrol1 Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5746 Oakland Road 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed 3 X Widowed 4 □ Divorced Specify: Year or Dates. 1953-55 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Noce. Forecaster Gas & Electric Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hayden D. Perkey Alma Loretta Frances 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Douglas E. Perkey (Son) 2065 Bancroft Lane, Mt. Pleasant, SC 29466 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lake View Mem. Park 5/21/2012 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Renal Disease END Stage disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Error Uncertainty Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for Pregnant at time of death 1 ∐ Yes 2 L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other:
4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 Accident Investigation 1 Yes 2 No after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor

To the Fune

completely f (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ٥ 29c. License number DSRyipinaMo 29d. Date signed (Month, Day, Year) 10005 7463 5/18/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar S. Rallipakse MD

31. Date filed (Month, Day, Year) MAY 2 1 2012 2835

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DHMH 17 Rev 06-2011

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Ballmore NID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles J. Rondo 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Daltimore ESSEX JURY VIRU omi If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 219-01-3645 07/04/1920 Maryland Director 1 XM 2 - F 91 show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director notified 28a-f 1 🗌 Yes 2 🔀 No Maryland Baltimore Chase 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 must be r Funeral 6840 Leslie Road 21220 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, ural", or iten Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates. WW Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: WWII Completed 3X Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker the Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever မ Antonio Rondo Maria Conti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debi Rondo - Daughter 4110 Frdman Avenue Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Most Moly Redeemer Cemetery 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State ō Department of Important: If any injury or 05/22/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, 21. Signature of Funeral Service Licensee Maryland 21231 Part 1 Enter the disease of co shock or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on _ach line. Part Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) ue to (or as a consequence of): **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Dav Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 No veral Director. After this certificate has filled in by the funeral director, page 2.3 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ဥ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗙 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Extifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) [Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day,

Year

MAY 1 8 201

Registrar's Signature

32.

ROSS, GERALDING.

				ack Indelible Ink. Ensure All Copie	_								
			1 - State of Maryland State of Maryland	/ Department of Health and Mental Hy Certificate of Death	/giene 201	2 1602							
	Physicia	in/	Decedent's Name (First, Middle, Last) GERALDINE ROSS	2. Date of D Month	eath Day Year	3. Time of Death							
,,,,,	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltmore City	4c. County of Deat								
)	Funeral		Sinui Hospital of Baltmore 5. Social Security Number 6. Sex 7. Age (In yrs. last I	irth 9. Bir	thplace (State or Foreign								
	Director		173-26-0550 1	$3-26-0550$ 1 \square M 2 $\cancel{\times}$ F 78 Yrs. Months Days Hours Min. 7 (Month, Day, Year) 7 $\cancel{18/1933}$ VIF									
	aryland a-f shov ied at	ctor	1 1 1	own or Location PPER MARLBORO	_	10d. Inside City Limits 1 Yes 2 □ No							
	h the Ma ka or 28 be noti	Funeral Director	10e. Street and Number 3503 ETON DR	10f. Zip Code 2 0 7 7 2	10g. Citizen of What Co	ountry?							
	eath wit tems 23 er must	Funer	11. Marital Status 12, Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No									
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by I	1 ☐ Never Married 2 ☐ Married 1 ☐ Ves 2 ☐ No 1 ☐ Ves 2 ☐ No 1 ☐ Ves 3 ☐ Vidowed 4 ☐ Divorced Armed Forces? 1 ☐ Ves 2 ☐ No 1f Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:	Black, Whit								
215-	iin 72 ho ie. han "na e Medic	omple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business ACCOUNTIN	•							
d 21	filed with al Hygier d other the	Be	1 2 ± h 17. Father's Name (First, Middle, Last)	BOOKKEEPER 18. Mother's Name (First, Middle		VG							
rylan	should be fill and Mental 7 is marked or raumatic eve	10	CURTIS CHERRY	18. Mother's Name (First, Middle ANNIE PEGR									
, Ma	and 2 sho Health and tem 27 is I		DEBRA CRAWFORD/DAUGHTER 3	19b. Mailing Address (Street and Number or Rural Route Numb 3503 ETON DR. UPPER MARL									
Baltimore, Maryland	age 1 al ent of H nt: If itel ry or oth		1 X Burial 2 Cremation 3 Removal from State ceme	e of Disposition (Name of etery, crematory or other place) THWOOD CEMETERY 5/21/12	20c. Location - City or PHILADELI								
Baltii	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signatur of Funeral Service Ocensel	22. Name and Address of Facility CAPITOL	MORTUARY								
			23a. Part 1. Enter the disease, or complications that caused the death. If shock, or heart failure List only one cause on each line.	TIES THREE BILLS IT. D IV.		20002 Approximate Interval Between							
	Physician/ Medical	6 3	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)			Onset and Death 2days							
Second Control	Examiner	Examiner	Sequentially list conditions, b. ISCHEMIC B	owel.		20045							
J.	executed an and rial-transit		if any, leading to immediate cause. Error Underlying Cause (Disease or linjury that initiated events c.										
No.	be executivision and solutions burial-tran		resulting in death) Last Due to (or as a consequence d.	ce of):									
9876	rtificate ling phy e as the	/Medi	IE EEMALE:										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3 🔲 Ectopic pregnancy	23d. Date of de Month	livery Day Year							
ds, P.O	quires that t en signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting to CNKONIC WECHANICAL VENTIATION, ESK.	(FF 25 (.)	tobacco use contribute to								
Division of Vital Records, P.O.	The law recate has be page 2 sho	Completed	MRSA BUCHEREMIA, C DIFF COlitis.	per	opsy prior to death?	topsy findings available completion of cause of s 2 DNo							
Vital	ysician: is certifi director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	26. Place of Death (Check only one) Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Res	idence 6 Other (Spec	rifv)							
n of	ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)		how injury occurred								
ivisio	or Atten after deal Director: In by the	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office 28f. Location	(Street and Number or Ru wn, State)	rai Route Number,							
	Hospita 4 hours Funeral ted filled	Medical	29a. Certifier 11 Certifying Physician: To the best of my knowledg (Check 2 Medical Examiner: On the basis of examination an	ge, death occured at the time, date and place, and due to the c d/or investigation, in my opinion, death occurred at the time, date	ause(s) and manner as sta	ated. cause(s) and manner stated.							
	To the within 7 To the comple	Ň	only one) 3 L Certifying Nurse Practioner: To the best of my known 29b. Signature and title of certifier	owledge, death occurred at the time, date and place, and due to t 29c. License number	he cause(s) and manner as 29d. Date signed (Monti								
	l_i		30. Name and address of person who completed cause of death (Item 23)	RES-000	Mayı	1,2012.							
	4		Aileen Pan, MD Sinai Hospit	a) of Baltimore									
	Stat Registra		31. Date filed (Month, Day, Year) NAY 2 1 2012 August 32. Registrar's Sichature	W									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of	Marylan		artment of		and M	1ental Hy	giene		
		State Registrar	/ cotl		Cer	tificate of	Death		2. Date of Dea	Reg. No. 2	112	16022
Physici		Decedent's Name (First, Middle, MILDED	DICIP	OT CUMOND						2012	3. Time of Death 7:30 P M	
Med Exami		MILDRED 4a. Facility Name (if not institution,		RICHMOND 4b. City, Town, or Location of Death				MAY	4c. County of Death			
1		ENVOY OF PIK		PIKESVILLE						ALTIM	ORE	
Funera			6. Sex 7	. Age (In yrs. Ia	nst birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Birt		9. Birthp Count	lace (State or Foreign
Directo		213-12-6050 Usual Residence of Decedent		93	TIS.				11/13	/1918		MD
land show	ξ	10a. State 10b. County		10c. City	, Town or Loc	ation					1	0d. Inside City Limits
Mary 28a-1 notifie	irec		ALTIMORE		BALT							1 Yes 2 XNo
ith the 23a or st be r	宣	10e. Street and Number		10f. Zip Code	.208			10g. Citizen of What Country?				
ING Z1Z13-UU30 I filed within 72 hours after death with the Maryland tal Hygiene. at other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	7 GALA LANE	12. Was Deced	ent Ever in U.S		Vas Decedent of	Hispanic Ori	gin? (Spe	cify Yes or No-	USA 14. Rac	e - America	an Indian.
fter de ', or it amine	þ	1 Never Married 2 Marr	Armed Force 1 Yes 2 If Yes, Give	es? 2 ∐XNo	1	Yes, specify Cu			Rican, etc.)	Blac	ck, White, e	
Z15-UU36 in 72 hours after e. nan "natural", o Medical Exam	Completed	3 Widowed 4 Divorced	Year or Date	es.						Specify	W	HITE
72 ho	l du	(Specify only highe	st grade completed) College (1-4	- 5)	(Give k	ent's Usual Occi ind of work done O NOT use retire	e during most	t of worki	ng	16b. Kind of B	usiness Inc	lustry
withir giene ser that		Elementary/Seconday (0-12)	College (1-4	or 5+)	НО	MEMAKER				OW.	N HOM	E
/Iang z1z15-UU36 d be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f sho tite event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Li	ast)						e (First, Middle,	Maiden Surnam	,	
a i i i	-	SAM 19a. Informant's Name/Relationsh	in (Type Print)	W.L.	LSON	. A.I.I (O)		RAH	15 / 1/	r, City or Town, S		TLEMAN
Mal		BARRY RICHMONI			1	gadaress (stree GALA LAN				21208	state, zip C	oaej
ore, of Hea if item rother		20a. Method of Disposition 1 X Burial 2 Cremation			lace of Dispos	sition (Name of natory or other pi			Date	20c. Location	- City or To	wn, State
EXILIMONE cermit. Page 1 a cepartmen of H mportant: If ite ny injury or ott nce.	1	4 Donation 5 Other (S	pecify)	iaic	R SINA	I CEMET	ERY		8/2012			LLS, MD
ermit. epartri mporta		21. Signature of Funeral Service	Ceneco							SON & B	-	
		23a. Part 1. Enter the disease or	complications that ca	used the death							LE, FI	Approximate
-Ph, sician		shock, or heart failure. List or Immediate Cause (Final disease or condition		ASTL	PNCEN	_						Interval Between Onset and Death
Medica Examine		resulting in death)	Due to (or	as a conseque	ence of):							
A FIRE	ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ence of):						-	
d d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C		-						- 1	
ate be executed bhysician and the burial-transit	E E	resulting in death) Last		as a conseque	ence of):							
physic the bi	edical		d									
certific	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar	ncy	le.				23d. Da	te of delive	ry
death death he atter	Completed by Physician/M	in the past 12 months? 1 Yes 2 No	4 Pregna	int at time of de	eath 5	Ectopic pregna Other (specify)	ncy			Мо	nth	Day Year
at the detach	F.	9 ☐ Unknown Part I (Other significant condition	ns contributing to dea	th but not resu	alting in the ur	nderlying cause	given in Part	l.	23e. Did to	bacco use cont	ribute to the	e cause of death?
J. T.	d b	DEMBNIA										ably 4 🗆 Unknown
ecords, e law requires has been sig ge 2 should b	plet								24a. Was a		Were autop	sy findings available
The la	Com						_		autop perfor 1 \(\sum \) Yes	rmed?_	death?	
VILCII ysician: s certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Deat	th (Check	only one)			
g Phys g Phys er this	e: To	1 Yes 2 No 27. Manner of Death	1 ☐ In	patient 2 E injury	ER/Outpatient 28b. Time of	28c. Inju	4 🗹 NL			ence 6 Other		
ending eath. or: Afte	icat	1 Natural 5 Pending 2 Accident Investig	ation	Day, Year)	injury	wo	ork? □ Yes 2 □		.ou. Dusonborn	aw mgary dodam		
or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place of	Injury - At hor , etc. (Specify)	me, farm, stre	et, factory, office		2	28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural	Route Number,
Spital nours a neral E		29a. Certifier 1 Certifying	Physician: To the bes	t of my knowle	edge, death o	ccured at the tim	ne. date and	place and	d due to the car	use(s) and mann	er as stated	1.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 Medical Ex		of examination	and/or investi	gation, in my opin	nion, death oc	curred at	the time, date a	nd place, and due	e to the cau	se(s) and manner stated.
To t To t		29b. Signature and title of certifier		~ .	2		se number			29d. Date signed		
h		30 Name and address of never-	the completed serve	of death (Item)			8852			UNY 1	7 2	0/2
3		30. Name and address of person w	9MINL 28	335 S	mith!	PUSNUE	1203	Bno	MILLON,	MAYIA	42	1209
Sta		31. Date filed (Month, Day, Year)	32 Aec	istrar's Signatu	1 7.	. 4.1						
Regist	ar	MAY 21	CUIZ Bu	was fo	7. 94	W.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	ryiand		artment of I tificate of I		and M		_	201	2	1 0	023
			Registrar 1. Decedent's Name (First, Middle, Las	t)	_		tineate or i	Jean	Т	2. Date of Dea	Reg. No	o. Z U]	-	3. Time o	f Death
	Physicia Medic		BESSIE	REZNICK						Month MAY	Da K	s zei	ar_	2	30 AM
part	Examin		4a. Facility Name (if not institution, give	4b. City, Town, or Location of Death											
			LEVINDALE HEBR									/ A			
	Funeral Director		5. Social Security Number 6. Sec. 216–16–9919 1 Usual Residence of Decedent						Min.	8. Date of Birt (Month, Da 09/26	22	9. Birthplace (State or Foreign Country) MD			
	and show at	اة	10a. State 10b. County		10c. City	, Town or Lo	cation						100	d. Inside C	ity Limits
	Maryla 8a-f tified	Director	MD N/A		В	ALTIM	ORE							1 X Yes	s 2 🗆 No
	a or 2 be no		10e. Street and Number	<u> </u>			10f. Zip Code				10g. Ci	itizen of What	Countr	y?	
	th with	Funeral	6603 PARK HEIGHT					1215				USA			
36	led within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	er in U.S. Io		Vas Decedent of H f Yes, specify Cuba 1 □ Yes 2 🏿 No	an, Mexica	n, Puerto R	ify Yes or No- ican, etc.)		14. Race - A Black, W Specify:	hite, et		
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Maryland	e d ta	To B	17. Father's Name (First, Middle, Last) MAX		PO	SINSKY	J	18. Moth		(First, Middle,	Maiden	Surname)	DΛ	SKIN	
ary.	should be fik n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Ty	pe, Print)	RO		ng Address (Street			Route Numbe	r City o	r Town State			
ž			VICTOR REZNICK/	HUSBAND		ì	PARK HEI						-		21215
ore,	ge 1 and 2 should be it of Health and Men it item 27 is marke or other traumatic		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		20b. Pl	ace of Dispo	sition (Name of natory or other place			ate		ocation - City			
ij	Page ment tant: I		4 Donation 5 Other (Specific				RTHODOX		05/18	3/2012		BALTI	MOR.	E, MD	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Fire real Secretary	ee			Name and Address REIS			L LEVIN			-		208
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the cause on each line.	the death					_	-		1	Approximat	
Į.	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. FAILUVE TO THOUSE Due to (or as a consequence of):								+	Onset and I	Death Celcs	
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	7 5	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due 15 (or as a nonsequence c):											
D	and trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to for as a	Due to (or as a consequence of):								+		
7	cate be executed physician and s the burial-transit		resulting in death) East	4											
160	icate	ledical		J											
99	eath certifica attending p	N/N	23b. Was decedent pregnant	23c. If yes, outcome of			Totopio programa					23d. Date of	delivery	/	
). Box	that the death red by the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at 1			Ectopic pregnand Other (specify)					Month	D	ay `	Year
<u>A</u>	v requires that s been signed t should be det	by	Part II. Other significant conditions co	ntributing to death but	t not resu	ılting in the u	inderlying cause gi	ven in Part	: I.			use contribute			
rds	equire een si nould	eted	Debression							1 📙 '	Yes 2	□ No 3 🖫			
Division of Vital Records, P.O.	sician: The law r s certificate has b lirector, page 2 sh	Completed	Huxlety									death	to com	pletion of c	
ita	certificant rector	8	25. Was case referred to predical examiner? 1 Yes 2 No	Hospital:			Oth	er.	ath (Check o					-	
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ou c	nding ath. r: Afte e fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,		injury	work		- 1	d. Describe ii	ov injui	y cocarroa			
ivisio	Il or Attending Physician: The la after death. Director: After this certificate ha d in by the funeral director, page	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury							d Number or Rural Route Number,				
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 L Medical Examination (Check 3 L Medical Examination (Check	ician: To the best of m ner: On the basis of exa e Practioner: To the be	amination	and/or invest	tigation, in my opinie	on, death o	ccurred at the	he time, date a	nd place	e, and due to the	ne caus		inner stated.
	To the within Comp.		9b. Signature and title of certifier 29c. License number 29d. Date signed (N								ite signed (Mo	nth, Da	y, Year)		
				Jun	MI)		03	03	17		N	lay 18	20	2	
_	10		30. Name and address of person who color			23a) (Type, F	Print) PAPUL	HEI	GIHTS	Ale	$\equiv Y_i$	BALT.	mi	212	15
	Stat Registra		31. Date filed (Month, Day, Year) - NAY 9 1 2	32. Figistrar	s Signatu	ure	ale								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ OU A M MINIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death town If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Min. 89 50-05-**Director** iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral d within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No "natural" 3 Widowed 4 Divorced Completed ac Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NPT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) an Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print Stef claughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ wan Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Signature of Funeral Service License 2211 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Krome disease or condition Medical resulting in death) **Examiner** 0 if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performer within 24 hours after death.

To the Funeral Director. After this certificate 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗌 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Investigation
6 Could not be 1 Yes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and of mirroring and on the cause of the basis of examination and of mirroring and of the cause of the basis of examination and of the cause of the basis of examination and of the cause of th the only one) and title of certific 29b. Signature 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 1

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a c Per FH G927 5/21/20/12 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decident's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1201 PM Physician/ a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Hospice Randallstown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Country) 214-32-7836 Director uly 8 1933 MD 1 M 2XXF 78 Yrs Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director MD Carroll Eldersburg 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21784 Funeral US 135 Klees Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, et 1 Never Married 2 Married Completed by White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gaither Herbert Vincent Heil Mary Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 135 Klees Mill Road, Eldersburg MD 21784 19a. Informant's Name/Relationship (Type, Print) Gerald T. Sargent, Sr (Husband) Winfield, MD

Burtonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Variety ematory Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) May 21, 2012 ion Cometery 22. Name and Address of Facility Burrier-Queen Funeral Home Signature of Funeral 1212 West Old Liberty Road, Winfield, MD 21784 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregrent in the past 12 months?
1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Other (specify) Pregnant at time of death Yes 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 25. Was case referred to p 26. Place of Death (Check only one) Be examiner? Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d, Date signed (Month, Day, Year) 29b. Signature and title State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 16 2012 07:31P ^M SCHAFFER MAY BEATRICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A KESWICK MULTICARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Min. Hours Director 217-18**-**5785 1 □ M 2 🛛 F 90 02/13/1922 MD Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD N/A BALTIMORE 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò "natural", or items 23a or edical Examiner must be Funeral 700 W. 40TH STREET 21211 USA · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumating once. ည ISIDORE RESNIKOFF REBECCA ZIMMERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18 WOODHOLME VILLAGE CT., BALTIMORE, MD 21208 MARLENE NUSINOV/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 05/18/2012 FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): xaminer Hoalt Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine s a consequence of) the burial-transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant a Pregnant at time of death Other (specify) igned by the air Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗹 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred t edical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Many r of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Number Practitioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title D006478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYINDRE, MD 21201 EUTAW ST SUITE 301, 31. Date filed (Month, Day; Year) 32.

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 05:19 JOSEPHINE AM STOCKS MAY 2012 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death BALTIMORE UDIVERSITY OF MARYLAND MEDICAL CENTER Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 049-32-5706 69 Director 1 M 2 W 10b. County 10a. State Town or Location 10d. Inside City Limits Director r 28a-f sl notified Baltimore MD 1 Yes 2 No 10e. Street and Number 2105 # 10g. Citizen of What Country? ō be 1 Allendale K Funeral 21216 23a death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married ☐ Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NO use retired) (Specify only highest grade completed) other than College (1-4 or 5+) the Be Department of Health and Mental F Important: If item 27 is marked o any injury or other traumatic eve မ or Town, State, Zip Code Method of Disposition Place of Disposition (N Woodlawn Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signs ure of Fun / I Service Licens 23a. Part 1. Enfer the shock, or lear disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph, sician/ ISCHEMIC BOWEL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** MYOCARDIAL INFARCTION Sequentially list conditions, Duel to for este consiscipence of cause. Enter Underlying Cause (Disease or injury Exami burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy or Month 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be CORONARY ARTERY DISEASE 2 No 3 Probably 4 Unknown peen DIABETES MELLITUS 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death? autopsy director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပု 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) D72527 MAY 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZZ S. GREENE ST., BALTIMORE, MD 21201 TIMOTHY PHELAN, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Medical institution, give stre 4c. County of Death ocation of Death **Examiner** timme 6. Sex Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 1 □ M 2 □ 0 23a or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No Completed by 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 tome Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zip Code) 2403719a. Informant's Name/Relationship (Type, Print) Washington DC Shirle Warcus 00 New 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cemete 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Facility me and Addres W 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each inc. . Do not enter the node of dying, cordiac or respiratory arrest, Approximate Interval Between
Onset and Death
Unlinew each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner nce of if any leading to immedicause. Enter Underlying Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical s, P.O. Box 68760 the phy as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Po in the past 12 month Month Day Pregnant at time of death 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Recor 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2. autopsy performe 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Williams, Hospital: Other: 1 🗌 Yes 2 No မ 1 🗐 Inpatient 2 🔲 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred ✓ Natural injury 5 Pending Accident 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21207 C hamdam State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ĨĨ, 2012 10:52P Helen Harrison Vaughn May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing & Rehabilitation Ctr Mt. Airy Carrol1 8. Date of Birth (Month, Day, Year) May 21, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1□ M 2□ F ΜD 85 1926 215-24-1767 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Sykesville MD Carroll 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21784 4911 Cherry Tree Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify. White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred E. Harrison Catherine M. Broderick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4911 Cherry Tree Lane, Sykesville, MD 21784 Mrs. Loretta Widerman (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ KBurial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's Cemetery 5/22/2012 | Poplar Springs, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Blian & Hay MO0764 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with HAILE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2₽ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page. Was case referred examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA

Physician: The law requires that the death certificate be executed and P.O. Box 68760. the attending physician signed by to Division or Vital Records, been has After this certificate Hospital or Attending death. within 24 hours after death Fo the Funeral Director: filled in by the

filed within 72 hours after death with the Maryland Hygiene.

3altimore, Maryland 21215-0036

Certification: To

27. Manner of Death

1 Natural

3 Suicide

2 Accident

4 Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 🗑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AND WOOD COUNT, STE 111, OLNEY, Mid

5 Pending investigation

6 Could not be determined

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APPLEGARTH Month THERINE 06.10 M 201 05 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ENCORE AT TURF VALLEY HON ARIS ELLICOTT CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Sept 19 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Maryland **Director** 215-09-6102 94 1917Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6002 Keithmont Court 21228 USA within 72 hours after death Fun 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" Completed 3X Widowed 4 □ Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s filed within 72 tal Hygiene. Baltimore Federal Elementary/Seconday (0-12) College (1-4 or 5+) the 10 Office Personnel Bank Juil be file auth and Mental Hy.

Juil them 27 is marked other or other traumatic ever Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic e Peter Balko Anna Piech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Applegarth/son 6002 Keithmont Court Catonsville,Maryland 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metro Crematory, Inc. 1
Burial 2
Cremation 3
Removal from State 5/23/2012 Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funer | Service Licensee Stephanie Custer | 22. Name and Address of Facility MacNabb Funeral Home, P.A. mule 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Physician/ DECOMPENSATED disease or condition resulting in death) Medical Due to (or as a consequence of Examiner FIBRILLATION ATRIAL CHRONIC YEARS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): KIDNEY FALLURE YEARS To the Hospital or Attending Physician: The law requires that the death certificate be executed CHRONIC attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical YEARS HYPERTENSION Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 URINARY TRACT INFECTION Completed 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY 32 A-3216 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s 1 ☐ Yes 2 🗶 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide 5 Pending injury work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a

To the Funeral Completed filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time date and place, and due to the cause(s) are manner as stated. 29b. Signatu and title of certifier 29c. License number 5 66 493 MARNLAND PHYSICIAN gr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BABATIDE KUNSEWE, MD 2835 SMITH AV SUITE 203, BALTIMORE, MD 21209 31. Date filed (Month, Day, Yea 32. Registrar Signatu MAY 2 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month MAY 100 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TIMORE ROR (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min. Director 1 - M 2 F 26-1 28a-f show Director should be filed within 72 hours after death with the Maryland Examiner must be notified at 10b. County ity, Town or Location 10d. Inside City Limits timore Yes 2 No ō 10f. Zip Code 10a. Citizen of What Country? 23a Funeral USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 ₩Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working Ve., DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementa Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. omesti Be sartield permit. Page 1 and 2 s Department of Health 1200 20b. Place of Disposition (Name of cemetery, crematory or other pla od of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Vaugh. C. Fille 5151 Balfo. Na 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as card Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) HRONIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con equence of) IJEAJE antid as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last signed by the attending physician Physician/Medical 0 Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December 4 time of death 5 Other (specify) for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year To the Hospital or Auton...
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by Translately filled in by the funeral director, page 2 should be detached for a manufactory. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Yes ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Registrar

State

00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REG

Date filed (Month, Day, Year,

AW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Beulah Addison Physician/ May 14, 2012 ey 8:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Services Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2XX Days July 27,1925 Country) 219-28-3768 86 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD **Baltimore** Baltimore 1 Tes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any njury or other traumatic event, the Medical Examiner must b once. 1525 North Rolling Road 21228 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XXVo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3√√√ Widowed 4 □ Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Mitchell Edith Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Robinson (Friend) 2000 Woodlawn Drive Apt. C Balto, MD 21207 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX urial 2 Cremation 3 Removal from State cemetery, crematory or other place) Parkwood Cemetery May 23,2012 Parkville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 Signature of Funeral Service Lengte 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ ST ADENOCA RCINOM ATIC Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUSINESS CENTER MA 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

MAY 2 2 2012

1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1:30 Sylvia Arrington 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMER MAHNOW (BUENTIT MISSIM DAZAG Mount 22cial Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min Country) unk 214-82-2665 **Director** 1 ☐ M 2🗓 F 56 -55 North Carolina Dec 9, 1956 Usual Residence of Decedent 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 28a-f DC 1 Yes 2 No Washington ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral tems 23a 6425 14th Street #101 "natural", or items 23 dical Examiner must 20289 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No by XX Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: black Completed 3 Divorced 4 Divorced er than "natur , the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygiene
7 is marked other the traumatic event, the Veteran Affairs 12 Program Specialist Be altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, unk ပ္ 27 is marker Roberta Arrington Leslie James Arrington 19WITTIE NJE AFRING TON-Smith-ne Ce Mailin 245es 4th an Street 1,5E WAShington DC to 2000 3
Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, MD 2091 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State MT. Oliver 5/23/2012 WAshington, DC 4 ☐ Donation 5 X Other (Specify) in state Name and oddress of Facility Mc aughlin Funeral Rome
2518 Pennsylvannia, AVE SE Wash. DC 20020 Ronal d Licen e Director Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anteuscycone Carolla Ascenter disease or condition resulting in death) Medical Due to (or as a prosequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Die to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialphysician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ō in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to predical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗆 Inpatient 2 🖫 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Homicide City or Town, State) 24 hours a Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature ad title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 351 dress of person who completed cause of death (Item 23a) (Type, Print) Name and 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Erskine E. Aller 2012 1:37 A_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Davs Hours Min. (Month, Day, Year) 4 98 082-26-9285 Director 1 🗶 M 2 🗆 F Yrs. June 5, 1934 New York Usual Residence of Decedent 28a-f show 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland 1 X Yes 2 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 868 Quince Orchard Blvd., #T-2 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U 14. Race - American Indian, 1953-Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1958 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ERSKINE id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Tennis Instructor Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank T. Aller Helen Lucille Merrifield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 1 and 2 s of Health item 27 Donna J. Aller /Wife 868 Quince Orchard Blvd., #T-2, Gaithersburg, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 18, 20c. Location - City or Town, State permit. Page 1 a Department of I Important; If ite any injury or of 1 X Burial 2 Cremation 3 Removal from State May Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2012 Rockville, Maryland Signature of Funeral Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. mystette Duni M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Pan 1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final failure Onset and Death acute renal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** artem COVONAM Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conse wence of) congestive or Attending Physician: The law requires that the death certificate be executed near that initiated events resulting in death) Last Due to (or as a consequence of): ysician Physician/Medical hypertengor Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 M No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation after death 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hd

To the Fun

completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 13,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Germantown, Manjond Vinu Ganti, MD 19129 Poctors Drive 31. Date filed (Month, Day, Year,

Registrar DHMH 17 Rev 06-2011 MAY 2 2 2012

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16036 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WESLEY **ASHBURN** STEVEN Month Physician/ 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
BALTIMORE MANOR CARE DULANEY VALLEY TOWSON If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 12/16/1952 MARYLAND Director 216 56 9901 1 🛛 M 2 🗆 F 59 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director ROSEDALE 1 Yes X No BALTIMORE 28a-f MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ms 23a or must be r Funeral 21237 USA 6214 GOLDEN RING ROAD ural", or items 2 I Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1972–78 Year or Dates. 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) DELIVERY PAPER Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WESLEY ANNA KRUG **ASHBURN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6214 GOLDEN RING ROAD BALTIMORE, MD 21237 ANNA ASHBURN/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 05/21/12 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE. 21237 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last the burial-tran attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Į, Day Pregnant at time of death Month Year ed by the a detached f been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has autopsy this certificate Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident the 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luther Ville, MD allscraft Way Asad 1012 31. Date filed (Month, Day, Year, 32. Registrar's Signatu State MAY 2 1 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bennett Elizabeth Physician/ Anne 2012 Medical . Eacility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Country) Months Days FIS 1 M 2 XF **Director** Yrs 1937 10d, Inside City Limits or 28a-f show 10b. County 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Examiner must be Funeral USA 23a Avenue death with Yale items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 2 X No 0 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nt of Health and Mental Hygiene.
It item 27 is marked other than or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Johns Hopkins Nursing Assistant 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Kebecca laylor William Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4112 Sinler Oaks Trail Onings Mills MD Casey Anthon 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 05 30 202 Cr Owings Mills, MD Forest 4 ☐ Donation 5 ☐ Other (Specify) Jarnson 22. Name and Address of Facility Vaugnn C. Greene Pineral Services 21. Signature of Funeral Service Licensee Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscherosis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Recdrds, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ► 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death?
1 ☐ Yes 2 ☐ No performed' Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manuer of Death 28c. Injury at work? 1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Director: A Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier on, in my or inion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Madical Examiner on 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058141 19,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21229 900 Avenue Wendie Williams S Caton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 2 2012 Registrar

			Pleas	se Type or Prii						gible.		
			1 State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I rtificate of I		lental Hy	2	012 1603		
ı	Physici		Decedent's Name (First, Middle, L	.ast)	- (timodio or i	Journ	2. Date of De	ath Day	3. Time of Death		
E	Exami		4a. Facility Name (if not institution, gi	y of Death								
	Funera	P	tarbart 5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	0 Pole of Pie				
	Director		215-42-7064	1 X M 2 □ F	72 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	Birthplace (State or Foreign Country)		
	ind thow	اۃ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation		July 9	, 1939	Maryland 10d. Inside City Limits		
	Maryla 28a-f s otified	rect	MD Baltin	more		nsville				1 \(\text{Yes 2} \) No		
	with the 23a or 3	Funeral Director	10e. Street and Number 927 Rambling Dr:	ive		10f. Zip Code	21228		10g. Citizen of US	What Country?		
	death r items iner m		11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto F	ify Yes or No-		ce - American Indian,		
21215-0036	ours after tural", or al Exami	ted by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ ↑ If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🛣 No	ck, White, etc. : white					
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	l withir ygiene her tha t, the		Elementary/Secondary (0-12)	College (1-4 or 5+	7	groomer			anin	mals		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last Myron Saul Bucl	kner				ne (First, Middle, Maiden Surname) Selle Rhinehart ral Route Number, City or Town, State, Zip Code)				
	nd 2 shou ealth and n 27 is m		19a. Informant's Name/Relationship Robert Krasniews				and Number or Rural Brive Ca			State, Zip Code) 21228		
Baltimore,	Page nent c ant: If		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Spec	cify)		sition (Name of natory or other plac	re) Da	ate	20c. Location -	- City or Town, State		
Balt	permit. Page Department Important: I any injury o		21. Signat e of Funeral Service Licer	Wale, Direc		Name and Addres	es of Facility	655 W	. Baltin	nore Street		
~	Physician/		23a. Part 1 Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	mplications that caused to one cause on each line.	he death. Do not ente	altimore,	g, such as cardiac or	respiratory arm	est,	Approximate Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of):	1000	y tai	Cott		hours		
£		iner	Sequentially list conditions,	b. Due to (or as a	consequence of):	Toole	acus		-	Low		
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							
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P.C	es that igned b	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.			ibute to the cause of death?		
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Whe Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed						24a. Was a autops perfor	med? d	Vere autopsy findings available vrior to completion of cause of leath? Yes 2 No		
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sion	Attendi death ctor: A cy the f	Certificate:	2 Accident Investigatio	on Oe Olean of Injury	- At home, farm, stre	M 1 🗆 1	Yes 2 □ No	4.1				
Div	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral or		4 ☐ Homicide determined	building, etc. (Specify)			City or Town	, State)	r or Rural Route Number,		
	the Hosp hin 24 ho the Fune npletely	Med	only one) 3 Certifying Nur	vician: To the best of my niner: On the basis of example Practitioner: To the b	mination and/or investi	gation, in my opinior	 death occurred at th 	e time date an	d place and due	to the cause(s) and manner stated		
	vitl cor	X	29b. Signature and title of certifier			29c. License				(Month, Day, Year)		
			30. Name and address of person who	completed cause of deat	th (Item 23a) (Type, Pr	int)	3306	,	y	6,2012 treet 21225		
		Ų	Jean, he	Journal	300		H dta	000	15 51	treet 21225		
	Stat Registra	9	B1. Date filed (Month, Day, Year)	2. Registrar's	Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 17, Physician/ 2012 9:45 A M Frederick Milton Biggs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8915 Seneca Lane Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 215-26-8902 Director 1 X M 2 □ F 91 May 16, 1921 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Montgomery Bethesda 1 Yes 2 X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8915 Seneca Lane 20817 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Year or Dates. WWII White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
National Institutes (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) of Health Research Documentation Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be t May Alberta Carter Elbridge Frederick Biggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Davenport Biggs/Son 16 5th Street, N.E., Washington, D.C. Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot June 2. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 2012 4 Donation 5 Other (Specify) Frederick, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 William a. M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ORUNARY ARTERY disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♠No 24a, Was an has autopsy this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 PRIO Other: 1 🔲 Yes မ 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lew, UD 7118112 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

124

State Registrar Truong Bao, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

10110 Molecular Drive #206, Rockville, Maryland

12-03206 Bryant Bates Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

yani Dates		1- For State Registrar State of Maryland / Department of Healt Certificate of Death			, No. 201	2 1604
Physici		1. Decedent's Name (First, Middle,Last)		2. Date of Death	3.140.	3. Time of Death
edical Exami	ner	21 yane baces	own, or Location of Death	April 24, 20		1815 hrs
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Funeral Director		5. Social Security Number unk 6. Sex 1 M 2 F 58 Yrs. Honder		8. Date of Birth	(MM/DD/YYYY) 9. Bir Foreig	thplace (State or an unk untry)
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Baltimore, I permit. Pages I and Department of Healt Important: If item iojury or other tran			dress of Facility Ana Comy Boar	rd 655 W	. Baltimor	e Street
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	Ë	27 Manner of Dooth 28a Date of Injury 28h Time of Injury 28a		28d. Describe how	w injury occurred	
Division tal or Atteodi	catic	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, of	1 Yes 2 No	29f Location (Sta	net and Number or Dur	al Davida Number City
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To the Hospital within 24 hours a To the Fuoeral Completely filled	Medical	Certifying Physician: To the best of my knowledge, death occurred at the tin (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my op and manner stated.	pinion, death occurred at	the time, date an	d place, and due to the	cause(s)
	2		License number O.C.M.E.		9d. Date signed <i>(Mon</i> April 25, 2012	th, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)			, = 7, = 3 12	
			ore Street, Baltimore	e, MD 21223		
Sta Regist	_					
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible July Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MA William Francis Bender, Jr. 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BAHIMORE St. Agnes HOSDITAI . Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) 218-40-9224 Director 1 **X** M 2 \square F Yrs. 69 Sept.6, 1942 Usual Residence of Decedent MD 28a-f show 0a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 117 Oak Drive 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event the once." 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Computer Software Contracts Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Francis Bender Eleanor Ahern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Oak Drive; Catonsville, MD 21228 Joan Bender Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 5/19/2012 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD 22 Name and Address of FacilitSterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee MO1050 1630 Edmondson Avenue; Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death 1 ARCHON Ph_sician/ MYOCARdIA Medical r as a consequence of Examiner BLAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-tran ue to (or as a consequence of) Division of Vital Records, P.O. Box 68760 @ Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy performed death? 1 Yes 2 No Yes 2 No Bender, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at \ work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending injury ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cer 0 900 S, CATON AVR who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Michel Bernein 10:55 PM Mou Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville North Beechwood Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours Months 80 Director 119-34-8110 1 🕅 M 2 🗆 F Aug.4, 1931 France Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland must be notified at Director 1 Yes 2X No Catonsville MD Baltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ō Funeral "natural", or items 23a edical Examiner must b 21228 IISA 2 North Beechwood Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Ves Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Chef 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Marie Raymonde Lucien Etienne Beaupin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 North Beechwood Avenue; Catonsville, MD 21228 Michele Beaupin Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5/21/2012 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Libenses m01050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardio Mikombotic event Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): cardiovasiular diseast **Examiner** al Meroschirchic Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ctopic pregnancy
5 Other (specify) Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No After this certificate Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one)

29b. Signature and title of certifier

N's Rujagaksemb 31. Date filed (Month, Day, Year)
NAY 2 2 2012

Maggidiumo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

P

Smilh AV

Registrar's Signature

29c. License number

10057465

29d. Date signed (Month, Day, Year)

5703 Baltimore MD 21205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 4:30 A M Stanly Bernard Berkemeyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sandy Spring Montgomery Friends Nursing Home **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min Hours 579-32-8444 Director 1 M 2 X F 1921 90 Dec 23, North Carolina show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2X No MD Sandy Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 17340 Quaker Lane #D-21 20860 United States death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner þ "natural", or 1 Never Married 2X Married 2 XNo Yes, Gir Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify Completed 3 Divorced 4 Divorced Caucasian Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ Social Worker Justice System other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I မှ Page 1 and 2 should be William Bernard Adeline Claypoole and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Donald J. Berkemeyer / Husband 17340 Quaker Ln. #D-21 Sandy Spring, MD 20860 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If if injury or 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/22/2012 Woodbine, Maryland permit. 21. Signal of Funeral Service Consecutive Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MO1251 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 3 months End Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo detached for Month Day Year Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the g Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \quad Yes Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 X Natural injury 5 Pending 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Typ

Georgia Ave.

9801

Merlyn Vemurý

29c. License number

ver Spring,

D35791

MD 20902

29d. Date signed (Month, Day, Year,

May 21, 2012

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.															
	State of Maryland / Department of Health and Mental Hygiene															
			1 - State Registrar Certificate of Death Reg. No. 2													
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Guinevere Robin	Year		e of Death										
	Medic	al	4a. Facility Name (if not institution, give stre	012		5 P. M										
1	Examin	er	Senator Bob Hooper		2	4b. City, Town, or Forest 1		Death		4c. Count		th				
المحاورية	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 2		8. Date of Birth	Harf	9 Rin		te or Foreign			
	Director		215-30-7763 1 M 2 MF 78 Yrs. Months Days Hours Min. (Month, Day, Year) Co. June 17, 1933 Mar.													
												10d. Inside	e City Limits			
	faryla Ba-f s	Maryland Harford Havre de Grace 10e. Street and Number 10g. City Town or Location How de Grace 10e. Street and Number 10g. City Town of Location Havre de Grace 10g. Street and Number 10g. City Town of Location Havre de Grace 10g. Street and Number 10g. City Town of Location Havre de Grace 10g. City Town of Location Havre											Yes 2. No			
	the N	10e. Street and Number 10f. Zip Code 10g. Citizen of Wr														
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	daati r Item Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)										merican Indian, /hite, etc.				
920	s eftar al", o Exam	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.		1 ☐ Yes 2XXXNo	Specify:				Bla					
5	hour	olete	15. Decedent's Educ	ation		edent's Usual Occupa			- 1	16b Kind of E Baltimo	Business/	/Industry				
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20	ad wit Hygian Ither i	Be C	12. 17. Father's Name (First, Middle, Last)	5+		1	40.14.11									
auc	ba fils antal I ked o ked o	70 E	Hubert Raynor						(First, Middle, N Thews	faiden Surnam	ie)					
ary	hould and Mi s mar umat		19a. Informant's Name/Relationship (Type	, Print)	19b. Mai	ling Address (Street a	and Number	r or Rurai	l Route Number.	City or Town.	State. Ziu	o Code)				
Σ	nd 2 slath e n 27 l		Lisa Robinson / Dav	ıghter		Woodland G				•			1001			
ore	atar coffe roth	1000	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	20b. F	Place of Disc	osition (Name of		May ^c		20c. Location	- City or	Town, State	9			
Baltimore, Maryland 21215-0036	t. Pag tmant tant: ijury c		4 ☐ Donation 5 ☐ Other (Specify)	EV	<u> 301 A1</u>		PC1	20	12 E	orest						
Ba	parmit. Paga 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mantell Hyglene. Depertment of Health and Mantell Hyglene. Depertment if the Z7 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Evanilher must be notified at once.		21. Signature of Juneral Service Licensee	avil	Ę	2. Name and Addres	ss of Facility	Hape:	1 & Cre	nation	Serv	vice-B	elAir			
			23a. Part 1. Enter the disease, or complic		- 13	Newbort	prive	FOL	est HII.	Mary	land	210 Approxi	50			
	Physician/		shock, or heart failure. List only one Immediate Cause (Final	caus (or each line.			9,		. respiratory and			Interval	Between and Death			
j.	Medical		disease or condition resulting in death) a.	END STAGE R Due to (or as a consequence)		DISEASE										
	Examiner		Sequentially list conditions, b.									!				
X	p #	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	uence of):											
PV	exacutad ian and urial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):											
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376	ficata g phy as the	Medi			_											
Box 68760	h cert tandin rr use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12_months?	c. If yes, outcome of pregna 1 Live Birth 2 Feta		Ectopic pregnanc	:v			23d. D	ate of de	livery				
Bo	daat the at had fo	ysic	1 Yes 2 X No	4 Pregnant at time of 9 Unknown	death 5	Other (specify)				М	onth	Day	Year			
<u>о</u> .	hat the ed by datac	y Ph	Part II. Other significant conditions conti	ributing to death but not res	ulting in the	underlying cause giv	ren in Part I.		23e. Did tol	acco use con	tribute to	the cause	of death?			
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Ö	w req	Completed							24a. Was a				igs available			
Bec	The la ata he paga	Som.							autops perfori 1 Yes	ned?	death?	s 2 No	of cause of			
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Ž.	Physic this c	2	1 ☐ Yes 2 💆 No Pro	spital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2			4 ☐ Nur					ify) HOO	PER HOU			
Division of Vital Records,	ding th. After a funa	Certificate:	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time o injury	work		- L	28d. Describe ho	w injury occur	red					
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<u>∻</u>	talor irs afte al Dir led In			building, etc. (Specif)	"				City or Town	, State)						
	Hospi 24 hou Funer tely fil	Medical	(Check 2 L Medical Examine	an: To the best of my know	n and/or inve	stigation, in my opinio	n, death occ	curred at	the time, date an	d place, and di	ue to the	cause(s) and	manner stated.			
	To the Hospital or Attending Physician: The law requires that the daath certificata be within 24 hours after death. Within 25 hours after death this cartificata hes been signed by the attanding physici To the Luneral Director. After this cartificata hes been signed by the attanding physici complately filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	ž		Practitioner: To the best of	ny knowledg	e, death occurred at the	he time, date	e and pla	ce, and due to th	e cause(s) and	manner a	as stated.				
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	5		30. Name and address of person who com	ipleted cause of death (Item	1 23a) (Type,	Print)	000	10	<u> </u>	0/10	101	0/0	<u> </u>			
	2		TRACIE L. MORGAN	CRNP 2300	DULAN	EY VALLEY	RD.	TIMO	NIUM, M	D 2109	3					
	Stat	e	31. Date filed (Month, Day (Year)	32. Registrar's Sign	are											

9:55 p.m.

MAY 17, 2012

GUINEVERE BERRY

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BULL ECICARD 1650 PM HORST MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Howard County General Hospital Columbia Howard Social Security Number 6. Sex 1 \(\text{M} \) 2 \(\text{F} \) 8. Date of Birth (Month, Day, Year) 06/11/1942 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 010-36-5665 Days Country) 69 **Director** Germany Usual Residence of Decedent 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director OH Cuyahoga 1 X Yes 2 No Strongsville 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 10819 Watercress Road 44149 ural", or items **USA** Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the Ith and Mental Hygien 27 is marked other turaumatic event, the Internal Audit Director Finance 4 4 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Egon Bull Charlotte Schmidt 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Susan Bull / Wife 10819 Watercress Road, Strongsville, OH 44149 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō ò 5/18/2012 Department of Important: If any injury or any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Aortic Physician/ Dissection disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injur signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Tyes Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 26a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 26b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Schubelm, MD 00070109 15 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESTEBAN SCHABFLMAN 5755 Cedar LN Columbia, MD State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perff, 6927, 5722/2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month MN4 Year 20 / 2 Ronald Baker 10 0610 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death . SALISBUTY HICOMICO TENINSULA KAGIUNAL If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Country) Maryland Davs Min. (Month, Day, Year) 10/04/1953 Hours 1 M 2 □ F Director 215-58-5949 58 Yrs. Usual Residence of Deceden permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be not that once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Poplar 34789 Popular Funeral Neck Road 21850 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Completed 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Waterman Fishing 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest A. Baker Elizabeth P. Truitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31770 Womach Road, Laurel, DE 19956 Carolyn Hitchens / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/14/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Mailie Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ TULMONAY Medical resulting in death) Examiner 40coroinL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (nearly) 23b. Was decedent pregnant 23d. Date of delivery erai Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tes 2 🗆 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? (<u>유</u> 1 🗆 Yes Other: 2 🛛 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 🔀 Natural injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause of the cause o 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E CARRUIL aibar strar's Signature State Registrar DHMH 17 Rev 06-2011

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who cor

31. Date filed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

RSH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N TIMORE IT AGNE Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Unde **Funeral** Country) Mary Months Hours 1 🗆 M 2 🕼 212-34-8877 77 Yrs Director and Usual Residence of Deceden 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore items 23a or 28a-f s ner must be notified 1 Yes 2 No Maryland 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral Denrose 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Yes, specify Cuban Mexican, Puerto Rican, etc. Black, White, etc. ō, 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after If Yes, Give Year or Dates. 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 7 is marked other than "r raumatic event, the Med Securit Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Admi æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorse E. Mac . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Darlene Barber - daughter Penrase Baltimore Marylan 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Page 1 g emetery, crematory or other 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee, 357 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner MONTHS Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year as been signed by the a 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 2 No Yes 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) re and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATON AVENUE, BALTIMORE 900 , MID CATHERINE sistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #20a-c&22 Per FH G927 5/29/2012 III
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** unthra 2612 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Genesis Homewood Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🔽 F Yrs. 61 May 15, Maryland Director 217-54-1042 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show 1√2 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 2809 Elgin Avenue USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes. Give Specify: black Completed by 3

Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Leroy Powell Florine Garner ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Florine Powell/mother 2609 Elgin Avenue Baltimore, MD item 27 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 5/23/2012 Atlantic Crematory Glen Burnie,MD 4 □ Donation 5 △ Other (Specify) in state 22. Simplicaty - Gremation& Funeral Services Nade 21. Signature of Funeral Service Licensee Ronald S State Anatomy Board 655 W. Baltimor Baltimore, MD 21201 7090 Ridge RD Director e Street Hanover,MD 23a. Part. Enter the disease, or c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21076 shoc or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or condition resulting in death) amy **Physician** /Medical Due to (or as a consequence of): Examiner hechacterum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Ž ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DODA5 430 Genesis Home woo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21212 Ana Maria 6000

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day David W. Cubbage Medical 2012 May 9, 50 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 18 W. High Street #2 Washington <u>Hancock</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 220-58-4038 57 1 🔀 M 2 🗆 F **Director** Apr 29, 1955 Maryland Usual Residence of Dece show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 🔀 No 28a-f Hancock MD Washington 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21750 18 W. High Street items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?

1 Yes 24 No
If Yes, Give Black, White, etc 0. þ 1 X Never Married 2 - Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: white "natural", 3 Divorced 4 Divorced Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 laborer construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Firem 27 is marked o မ John William Cubbage Patricia Ann Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cubbage/father 124 Fulton Street Hancock, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signatur at Euneral Service Licensee ²State Anatomy Board 655 W. Baltimore Street xector MD Baltimore. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, on heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician Metastatic ears disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any leading cause. Enter Underlying Examiner Due to (or as a consequence of Cause (Disease or injury that initiated events tran and Due to (or as a consequence of): burial-1 resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Ď in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform Yes 2 certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2**X** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dia 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yong tang, wo 1130 Opal A, Haferstown,

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Month May Physician/ 12:50 PM 16 Ryan G. Cotterell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 🙀 M 2 🗆 F Months Hours Min July 26, Maryland 1917 **Director** 217-09-2506 94 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1

Yes 2 □ No Baltimore MD ö 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 21212 205 Taplow Road items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. or 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Completed by within 72 hours after Baltimore, Maryland 21215-0036 White Page 1 and 2 should be filed within 72 hours and thent of Health and Mental Hygiene. Trant: If fem 27 is marked other than "natural", trant: If fem 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify Specify: 3 🛮 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fairfield Medical Accountant 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Ryan James Cotterell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Cotterell 205 Taplow Road; Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State Park Cemetery 5/21/2012 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Lorraine 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fun A Service Licensee MO123 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ou Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Attending Physician: The law requires that the death Month rate has been signed by the atte page 2 should be detached for Day Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 2 🗆 No 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Lives ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending work Found on Floor in room death. 2 Accident
3 Suicide
4 Homicide MAN 11 2012 1 ☐ Yes 2 X No D400' Investigation 6 Could not be 28e. Plac of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after Hospital or 6451 N. Charles ST, TOWSON MA To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ture and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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DHMH 17 Rev 7/2009

GALLES

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 16052 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 20:49 Norris E. Cox 2012 Medical a Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 246-70-3581 **Director** 1 🖾 M 2 🗆 F Yrs May 8, 1945 North Carolina 67 Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 435 Rosecroft Terrace 21229 USA items within 72 hours after death ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Heavy Equipment Mechanic the Be Jee, Marylar.

yermit. Page 1 and 2 should be filed.
Department of Health and Mentrill Important. If item 27 is any injury or out. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dewey Edgar Cox Gerta Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 Rosecroft Terrace; Baltimore, MD 21229 Mary Cox Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 5/22/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. . Signature of Funeral Service Licensee M01234 21228 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ Disease Coronary disease or condition INKNOWN Medical resulting in death) Due to (or as a consequence of) Examiner Social interestions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, F.O. Box 68760 the attending ph IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? page 2 should be detached for Month Day Pregnant at time of death 2 No Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation cular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Myocardial Infarction 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsv perform death? 2 🗌 No 1 Yes Yes the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 res 2 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) elle my DO058141 may 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21229 900 S. Caton Avenue Wendie Williams

State

Registrar

31. Date filed (Month, Day,

MAY 22

2012

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 2012 18 2:12 A Wirginia Smyser Cooke May 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cockeysville Baltimore Broadmead If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country) Hours PA 205-16-4844
Usual Residence of Deceder 1 □ M 2**X**□ F 90 Nov. 17 1921 Yrs 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2X No Cockeysville Baltimore 10g. Citizen of What Country? 10e. Street and Numbe USA 21030 Room 250 13801 York Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc 1 Never Married 2 Married Yes 2 X No white If Yes, Give Year or Dates 1 ☐ Yes X☐ No Specify: 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Virginia Gable Mathias Smyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12924 Meadow View Drive, Gaithersburg, MD Mrs. Barbara Christiansen/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Prospect Hill Cemetery 6/28/12 York, PA Donation 5 Other (Specify) 2. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
0 W. Padonia Rd., Timonium, MD 21093 Bryan W. Clary death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the lise ase, or complications that caused the shock, or hear failur. List only one cause on each line Approximate Interval Between Onset and Death Immediate Caus (Fin. disease or conditi resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregpant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day g Unknown 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner Examiner

and

page 2 should be detached for use as

signed by

After this

e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th

9

Records,

Division of

Physician/Medical

Completed by

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Certificate:

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10a. State

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23a

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1 and 2 sl of Health a item 27 is

Department of F Important: If ite any injury or otl

Medical Examiner

other traumatic event, the

must be notified at

Director

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 1 Yes 24a. Was an autopsy

3 Probably 4 Unknown

Yes 2 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

prior to co	psy findings available mpletion of cause of
death?	
1 Yes	2 No

2 1 No 1 Yes 27. Mann of Death Natural 5 Pending Accident Investigation 6 Could not be Suicide

determined

25. Was case referred to medical

4 Homicide

29a. Certifier

28a. Date of injury (Month, Day, Year)

28b. Time of 28c. Injury at 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28d, Describe how injury occurred 1 Yes 2 No

> 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year, MAY 2 2 2012 32. Registi

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and N	/lental Hygie	ne				
				ertificate of Death	Reg.	No. 2012	16051			
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Death 3. Time of De				
	Medic	al	Margaret K.	Crostic	Month 05	11 2012	01:22 a ^M			
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
_	Funeral	•	Gilchrist 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimor				
	Director		212-24-9077 1 M 2 🕱 F 83 Yrs.	Months Days Hours Min.	(Month, Day, Yea 09/14/19	Ou Ou Ou Ou Ou	nplace (State or Foreign Intry)			
	, MC		Usual Residence of Decedent		T 09/14/19	20	110			
	ryland -f sh	cto	10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits			
	r 28a notifi	Dire	MD Baltimore Perry F				1 Yeş 2 X No			
	/ith th	ral	ASOS Townships	10f. Zip Code 21236	1 -	Citizen of What Cou	untry?			
	ems r mu	Funeral Director	4802 Torpoint Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe		14. Race - Amer	iona Indian			
õ	fter d	ğ	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White				
3	tural'	Completed	3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 Yes 2 X No Specify:		Specify: Wh	ite			
ç	72 hc n "na 1edic	nple	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16b	. Kind of Business I	nd of Business Industry			
9500-61212	vithin jiene. er tha the N		Elementary/Seconday (0-12) College (1-4 or 5+) Hon	DO NOT use retired) ne Maker		Own Home				
פ	be filed within 72 hours after death with the Maryland lental Hygiene. rked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	æ	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	en Surname)				
Maryland	should be file and Mental 7 is marked or raumatic eve	오	EdwardJohn B	Leimig Helen	Ros	е	Hinkle			
Jar	shou and is m raum			ling Address (Street and Number or Rura						
ر ق	and 2 Health em 2; ther t			302 Torpoint Road,	Perry Hal	1, MD 212	36			
0	nt of I		1 🕱 Burial 2 Cremation 3 Removal from State	ematory or other place)		. Location - City or 1				
saitimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	<u>Valley</u> 05/24	4/2012 Ti	monium, M	laryland			
Ď	Dep Imp any		Departure Blan	22. Name and Address of Facility Lec 5305 Harford Road,	onard J. R Baltimore	luck, Inc. MD 2121	4			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			, , , , , , , , , , , , , , , , , , , ,	Approximate			
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	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	were the contract of the contr						
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00	tificat ng ph	d)	IF FEMALE:							
YOC O	th cel	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deliv	*			
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5	requires that the death certific been signed by the attending I should be detached for use as	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?			
Š,	quires en sigi uld be	edk	Debruly		1 🗆 Yes	2 No 3 □ Pro	bably 4 🗆 Unknown			
conna,	aw rec as bee 2 sho	Completed			24a. Was an	24b. Were auto	ppsy findings available ompletion of cause of			
ב ב	hysician: The law inic certificate has to director, page 2 s	Son			autopsy performed 1 \(\sum \) Yes 2 \(\overline{K}\)	? death?				
0	cian: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check			1,			
>	Physical direction	일	1 Yes 2 K No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time	, 1	me 5 Residence) Hospice			
-	ding th. : After	cate	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	28c. Injury at work? M 1 Yes 2 No	28d. Describe how in	jury occurred	,			
2	Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, s		28f. Location (Street a	Street and Number or Rural Route Number,				
2	ital or ins afte al Dir led in		building, etc. (Specify)		City or Town, Sta					
	Hosp Hosp Funer ted fil	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation in my opinion, death occurred at	the time date and pla	co and due to the co	usea(e) and manner stated			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 Certifying Nurse Practioner: To the best of my knowledge. 29b. Signature and title of gertifier	death occurred at the time, date and place	e, and due to the caus	e(s) and manner as s	lated.			
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			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) _ 2	(9				
			SYED B. ABBAS 6701 N Charles	Sheet Jule 4105	Baltin	iore MI	21204			
	State Registra	•	only one) 3 Certifying Nurse Practioner: To the best of my knowledge. 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, SED B. ABBAS 670 / N Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature	,						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Cavaliere 2012 Nancy 16:10 PM May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore City Baltimore Johns Hopkins Bayview Medical Center 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours January 16, Director 219-38-0904 Maryland 1941 1 □ M 2XX F Usual Residence of Decedent 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director notified Mary land Baltimore City Baltimore XX Yes 2 No 10f. Zip Code 21202 10e. Street and Numbe 9 must be 10g. Citizen of What Country? Funeral 23a 915 Eatern Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Examiner Armed Forces ori Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White "natural" Completed Specify: 3 - Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the B&O Railroad N/A Secretary 12 years traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Mary Irene Franckowiak Wade M. Church 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Eastern Avenue, BAltimore Maryland 21202 of Health in tem 27 Carin Cavaliere 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 Burial 2XX Cremation 3 Removal from State 5 Department Important: If any injury or once, 4 Donation 5 Other (Specify) 5/19/12 Towson, Maryland Hilltop Service Corp 21. Si lature o uneral Se 22. Name and Ruck Funeral Home of Dundalk, Inc. Fisher 7922 Wise Avenue, Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final and Death Physician/ disease or condition resulting in death) PLLEST ALDIAC LADING Medical Examiner Secure tight (let exactly as Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury e to (or as a conse quence of burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical requires that the death certificate be P.O. Box 68760 the t as 1 the attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 2XX No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2xx No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 🙀 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural (Month, Day, Year) 5 Pending work? 1 Yes Accident Investigation filled in by the the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29d. Date signed (Month, Day, Year) ೧ರ೧ d cause of death (Item 23a) (Type, Print) 4940 Easten Avenue Baltimore State MAY 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure, All Capies Are Legible.

AMEND TIEM# 23a, pt 1, perPHYS, G927, 57, 22, 2012, wS

State of Maryland / Department of Health and Mental Hygiene 16056 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROSIE CROWDER 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOPKINS HOSPITAL BALTIMORE C HEJOHNS N/A If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 2/22/1939 Hours **Director** 213-36-5282
Usual Residence of Decedent 1 M 2 X F 73 MD ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2021 E. North Ave. 21213 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 0 Yes 2 No Yes, Give Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) should be filed within and Mental Hygiene 11th Daycare Provider State Of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 0 Warren M. Epps Mary Eldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sie Cr<u>owder- So</u>n 2021 North Ave. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Calvary Cemt. 4/19/2012 Baltimore, MD f Funeral Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. ignature North Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Coronary Artery Disease**Cause (Final condition Ave. Baltimore, MD 21202 Approximate Interval Between te Cause (Final Onset and Death Physician. or condition ng in death) Medical Pince of): Diabetes Mellitus Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hypertension and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Congestive Heart Failure Division of Vital Records, P.O. Box 68760 as IF F8MALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death jo in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law has autopsy performed? No page death?
1 Yes 2 No 1 Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending the Accident Investigation within 24 hours after deatl To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D67633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltimore MD 2128 (000 Mustapha soh eeo WOIF 31. Date filed (Month, Day, Year) Registrar's Signature State 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar				Cer	tificate	e of D	eath			Reg. N	0.201	2		605	7	
	Dhysisis	" /	1. Decedent's Name (First, Middle, Last)														of Death	•	
	Physicia Medio		Shih Jun C	heng		May 18, 2012						2:0	5 A M	_					
	Examin	er	4a. Facility Name (if not in:	stitution, give s	treet and numbe	er)		4b. City,			of Death		40	County of D					
			Casey Hous 5. Social Security Number		7	. Age (In yrs. I	ast hirthday)	If Under	kvil	If Under	r 24 Hrs.	8. Date of Bir	Montgomery irth 9. Birthplace (State or Foreig						
	Funeral Director		212-96-1626]м 2 ∰ г	87	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Countr	ry)	e di i dieign		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itama 23a or 28a-f show with injury or other traumatic event, it a Medical Examiner must be notified at ance.		21. Signature of Juneral S	Service License	e	4 114						n Servi						Ī	
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Division of Vital Records, P.O.	frer d fred lract	Certificate:	4 ☐ Homicide	determined		of Injury - At h g, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory	y, office			28f. Location (City or To			Rural	Route Nu	ımber,		
<u> </u>	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	8	29a. Certifier 1. ℃ C	ertifying Physi	cian: To the be	et of my knou	ledge death	occurred a	t the time	date an	nd place a	nd due to the c	21150(5)	and manner a	e etate			_	
	Hos 24 h Fun letely	Medical	(Check 2 🗌 M	ledical Examin ertifying Nurse	er: On the basis	of examination	on and/or inves	tigation, in	my opinio	on, death	occurred a	the time, date	and plac	e, and due to t	he cau	ise(s) and	manner state	d.	
	Nithin Somp	2	29b. Signature and title o		Fractioner.	to the best of	my knowleage			number		acc, and due to		ate signed (M				-	
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			30. Name and address of		•	,												_	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 04:20 A_M Paul Donald Cole Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore County Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 215-28-9457 80 1 🖾 M 2 🗆 F 03/22/1932 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If ifem 27.5 is marked other than "natural", or items 23a or 28a-f shoury or orther traumatic event, it is "Addeal Examiner must be notified at ury or orther traumatic event, it is "Addeal Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 300 W. Ring Factory Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Police Department Detective 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret Whelan Elmer L. Cole, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2153 Baltimore Blvd., Finksburg, MD 21048 Donna Turwy - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or ot cemetery, crematory or other place Parkwood Cemetery 1 K Burial 2 Cremation 3 Removal from State 05/19/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, MD 21014 610 W. MacPhail Road., Bel Air, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) mente Medical Due 1 (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 XX မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinating and/or investigations. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 is of person who completed cause of death (Item 23a) (Type, Print) ST POWEN MO HARLURS

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

rianna Michelle	П	1- For State	State	e of Maryland		artment o <i>rtificate o</i>			vientai ny	/giene	Reg. I	No. 2	01	2 1605				
Physicia		Registrar 1. Decedent's Name	e (First, Middle, La	st)						2. Date of			,	3. Time of Death				
Medical Exami	ner	Breanna	Miche	lle Calla	han			-	-ti	May 1	4, 2012	2 4c. County of		2205 hrs				
		4a. Facility Name (if Carroll Hosp		ve street and number)				minster	cation of Death			Carroll	Death					
Funeral		5. Social Security N	lumber 6.5	Sex 7. Age	e (In yrs. I	ast birthday)	If Und		If Under 24Hrs. Hours Min.	٦ .			Foreign	place (State or				
Director		177-72-		M 2XF	21	Yr		lo Boyo		9/6	/199	90	Cou	ntryPA				
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Maryland 28a-f show	ō	PA	Adams		L	ittles					T.,			YYes 2 No				
e Mary or 28a- fied at	ě	10e. Street and Nur 749 West		Stroot			10f. Zip	73 4 0			US	Citizen of Wh	iat Coun	Southly r				
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examioer must be notified at occe		11. Marital Status		12. Was Decedent			as Decede	ent of Hispar	nic Origin? (Sp		or No-	14. Race		American Indian, Black,				
or item	Funeral	1 XX Never Marrie		1 Yes 24	X No				exican, Puerto	Rican, etc	i.)	White Specify: \		- ۵				
irs after ural", miocr	ð	3 Widowed 15. Decedent's Ed		od If Yes, Give Year or Dates: only highest grade com	pleted)	16a. Decede	nt's Usual		(Give kind of v		16	Specify: N						
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Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma jojury or other traumatic er		21. Signature of Fu	neral Service Lice	ensee										vice D 21061				
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- Medical Examiner	9.7	failure. List on Immediate Cause (ly one cause on a	each line. a. Narcotic										Between Onset and Death				
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Box 68760, e death certificate be the attending physic ed for use as the bur		23b. Was decedent past 12 months	pregnant in the	1 Live birth		2 🗸 F	etal death		Ectopic pregna	ancy		Month		ay Year				
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IS, P quires t en sign uld be o	ted k									24a.	Was an	24b. \	Were au	topsy findings available				
Division of Vital Records, tal or attending Physiciae: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	<u> </u>									autopsy performe Yes 2	ed?	death?	ompletion of cause of				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physiciae: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	29a. Certifier 1 (Check only one) 2		ician: To the best of mer:On the basis of exa	y knowle mination	dge, death occi and/or investig	urred at the ation, in m	e time, date ny opinion, d	and place, and eath occurred a	due to that the time	e cause(s , date and	s) and manner d place, and c	r as state due to th	e cause(s)				
To witi	Mec	29b. Signature and		and manner stated.			29	c. License r		_		_		nth, Day, Year)				
		Heemed	This her	(limi)				O.C.M.	E.		^1	May 15, 20)12					
(\mathcal{O})			ess of person wh Southall, MD	o completed cause of o Assistant Med			00 W. B	altimore \$	Street, Balti	imore, N	/ID 212	23						
	tate	31. Date filed (Mon	th, Day, Year)	32. Registra	r's Signa	like												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04:10 PM RUTH L. CHRISTIAN Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Town, or Location of Death **Examiner** Agnes HOSPITA imore N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, Year) 77 Director 212-34-2437 1 □ M 2**XX** 2-15-1935 MARYLAND Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director N/A BALTIMORE 1 X Yes 2 ☐ No MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3600 W. FRANKLIN ST. APT 11R 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 ▼ Widowed 4 □ Divorced BLACK Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) -12--0-PRINT SHOP HECHT COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of 2 WILLIAM C. PINDLE PEARL E. MYERS other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or Astronauty or Astronaut 3610 FERNDALE AVE. BALTIMORE, MARYLAND 21207 KAREN BOHANNON (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Buria 2 Cremation 3 Removal from State 5-26-2012 BALTIMORE, MARYLAND WOODLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) D. HIBNER. Name and Address of FacilityPHILLIPS FUNERAL HOME. P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Onset and Death Physician/ Whonary disease or condition Medical resulting in death) Due to for as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami trar resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 88 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Dav the ☐ Unknown g Unknown JusistiAN, Putu signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 certificate 2 🗌 No 1 T Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No hours after death Accident Investigation Could not be within 24 hours after deat To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who d CATON AVE 900

Registrar DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 4 State of Maryland 4 Department of Health and Mental Lygiens 22/2012dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician Month 50 OU /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. City, Examiner Ba mne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 02 / 6 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign MD Country) **Funeral** Min. M 20 F Months Days Hours 216-52-8917 64 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinan training by rollified at 10c. City, Town or Location 10d. Inside City Limits Director 1√2Yes 2□No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 22 S. Athol Avenue USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? Married 1 □ Yes 2 No 111 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 No Specify. ð Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed uni 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk Laborer Factory Work 12 unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Dorsey Gladys Cooper 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
FULLIFIE CAPE TYPE Brother S. Athol Avenue Baltimore, Hellwig Road, Baltimore, MD permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) in state 21. Sign ture of superal Service Line nsee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 ector Baltimore, 3a Part 1 Enter the disease or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burlal-tran Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate ! Vital 1 ☐ Yes 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 100 Hospital: Other: 1∏Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred ision or Attending Natural 5 Pending investigation s after death.

I Director: A in by the fu 1 ☐ Yes 2 No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) ည 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

0

31. Date filed (Month, Day, Year) MAY 2 2 2012

pare

82

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Pate of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2605 Baltimore NIA Foorster . Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 216.42. Country **Director** OHO 1 M 2 XF TO Yrs. OB or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Foerster Avenue 21230 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black. White, etc. is marked other than "natural", or Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Black Year or Dates injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Domestic 12th grade seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kobert Spinner HUI Marian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. IVY Terrace Elkildre MD 21075 Moniar Young Daughter 6400 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2017 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn (. Greene Funeral Sonkes laughn Cc 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Intervie disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trar resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent predi 23d. Date of delivery in the past 12 month for Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 III the detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has nerformed 1 Yes 2 Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred after death. Natural 5 Pending Accident
Suicide
Homicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year narleen OWELL 10:35 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesia altimore Security Number 214 6. Sex Age (In vrs. last birthday) 24 Hrs. 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign **Funeral** 7-66-7362 Hours Min. Country Director 1 - M 2 F 54 Usual Resid 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 X Yes 2 No 0 10e. Street and Nu 10f. Zip Code 10g. Citizen of What Country? ^{mber} Exeter 23a Funeral 21218 USA 6 death v or items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?, 1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Completed by ld be filed within 72 hours after. Mental Hygiene. Maryland 21215-0036 1 Yes 2 No Specify Black is marked other than "natural", If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ_NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) isablea Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Sr DS Comb 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Important; If item 27 any injury or other tra een Kandal - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, MD 4 Donation 5 Other (Specify) 22/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility larch F/H-East 1101E. North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Me Brown disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 05 Sequentially list conditions, cause (Disease or injury that initiated events Due to for eac consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the 93 attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year the 1 ☐ Yes ∠ ≠ g ☐ Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by pe Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2. No 1 🗌 Yes Other ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the P only one 29b. Signature and title 29d. Date signed (Month, Day, Year) D0045430 16 o completed cause of death (Jem 23a) (Type, Print) Parkwar WD 21234 State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12 ay 2012 10:25 A M May Virginia S. Daniel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) 067-18-3979 **Director** 1 □ M 2 🛣 F 87 Yrs. January 25, 1925 Tennessee Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location death with the Maryland Director items 23a or 28a-f s ner must be notified 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 10248 Hatherleigh Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virgilia Pettit Samuel Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10248 Hatherleigh Drive, Bethesda, Maryland 20814 Clarence D. Daniel / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Montgomery Crematorium, Inc. 1 Durial 2 K Cremation 3 Removal from State May 16, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Nobert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 10 years Hypertension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami 10 years Dyslipidemia Due to (or as a consequence of) resulting in death) Last Physician/Medical The law equires that the death certificate be 687¢b attending phy as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy P.O. Box in the past 12 months?

1 Yes 2 X No Day 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, hould 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer injury X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year)

State

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Roger Stevenson, Jr M.D.

31. Date filed (Month, Day, Year)

MAY 2 2 2012

D20535

6410 Rockledge Drive #200, Bethesda, Maryland 20817

May 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Menth 93 Salvadore Peter Dignazio 2012 9:13 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (MoOth,/3ay,/1936 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Countraryland 215-30-9558 76 **Director** Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10 Troon Court 21236 USA items within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ Nair Force
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🏝 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. 3 Widowed 4 Divorced Specify Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Stonemason Construction injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Is Important: If item 27 is marked any injury or cat. 18. Mother's Name (First, Middle, Maiden Surname) ျ Angelo Dignazio, Sr. Rachel Amato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Dignazio / Wife 10 Troon Court, Baltimore, MD 21236 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 5/17/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Doroto (Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cholangeocarcin disease or condition resulting in death) Medical Due to (or as a presequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe eral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Katural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier May 15/12 2012 Street Suite 4105 Baltimore MD 21204 address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ixon 7:25 AM Medical Facility Name (if not institution, give stre City, Town, or Location of Death 4c. County of Death Examiner Himore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Maryland Days Min. Months Hours (M903/P2/Y931 61 216-54-1965 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Yes 2 ☐ No Princess Anne MD Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21853 USA 12883 Recycle Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑ Yes 2 □ NNavy 14. Race - American Indian Examiner Black, White, etc. o 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify Specify: White "natural", 3 Divorced 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grain Inspector Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Miller Joe Dixon, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1807 Jackson Road, Baltimore, MD 21222 Joe Dixon III / Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Beltsville, MD Chesapeake Crematory 5/18/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
UULTIVIO Immediate Cause (Final disease or condition resulting in death) Physician 71 West la Medical Due to (or as a co a quence of): Examiner Sequentially list conditions, if any, localing to immediate cause. Enter Underlying Due to (or as a consequence of Examin and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical P.O. Box 68760 as the nding IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Po Month Day 5 Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate has page 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) director Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Tyes ျှ ER/Outpatient 3 DOA After this 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work Natural hours after death. neral Director: Aft d filled in by the fur 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours a **the Funeral D** mpleted filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) nd address of person who completed cause of death (Item 23a) (Type, Print) 3900 aW, MI Day, 32. Registrar's State MAY 2 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0507AM 300 25 201 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death Cas 0 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) **Director** 212-38-1633 1 □ M 2 🗓 F 70 Yrs. 10-31-1941 MD Usual Residence of Decede ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 XNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 170 Morriss Court USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black White etc. 1 Never Married 2 X Married ş Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working hould be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file h and Mental F 7 is marked of Richard Goldring Dorothy Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 William E. Denton/husband 170 Morriss Court, Glen Burnie MD 21060 20a. Method of Bisposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o of Burial 2 X Crema on 3 - Removal from State Metro Crematory 5/22/2012 Catonsville MD 4 ☐ conation 5 ☐ Other (\$pecify) 22. Name and Address of Facility 21. Signature for neral Se re and Address of Facility

Kirkley-Ruddick Funeral Home

Crain Hwy SE Glen Burnie MD 21061 M01364 Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Betwee shock, or heart failure. List only one cause on each line. Onset and Death_ Immediate Cause (Final Physician/ 20 disease or condition thes asc 1701 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Divide for as a consecuency of cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 ☐ Yes 2 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 1 Natural Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pendina 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A

completely filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29c. License number me and address of person who completed cause of death (Item 23a) (Type, Print) 13 00 1) Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #205 are of Maryland / 5/24/2012 of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marie Doris Davis 10:24A M Medical May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 216-18-6461 Director 1 🗆 M 2 💢 F 90 Yrs. 25. 1921 Julv Maryland of Heelth end Mental Hyglene. Item 27 is merked other than "natural", or items 23e or 28e-f show other traumetic event, the Medical Exercitor must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 Walther Blvd. #1610 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White Specify: Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Bookkeeper Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Livingstone Kircher permit. Page 1 and 2 should bu Depertment of Heelth and Man Important: If Item 27 is merke any injury or other traumetic 900.68. 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn M. Davis/ Son 7168 Collingwood Court Elkridge, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Parelmann) are material or place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parwood Cemeterv 5-21-12 Baltimore, MD. 21. Signature of neral Service 22 Name and Address of Facility Funeral Home, Inc. a Ligans 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Friysician/ disease or condition MEDIASTINUM CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ettending physician end I for use es the buriei-trensit To the Hospital or Attending Physician: The lew requires thet the deeth certificate be executed within 24 hours effect deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the innerial director, page 2 should be deteched for use as the buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MARIE DAVIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 TOther (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide м 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. MORGAN, CRNP TIMONIUM, MD 21093 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 🌧 Physician/ 22:47M 2012 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ballimore Squale HUSPITCE Dseda 10 RANKLIN 9. Birthplace (State or Foreign 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, Year) Director 70 1 🛛 M 2 🗆 F Jan 3, 1942 ıral", or items 23a or 28a-f show I Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 ☐ No Rosedale MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21237 6600 Ridge Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No δ 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical unk unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry id Mental Hygiene. marked other than life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4 or 5+) unk Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 2 should be and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Page 1 and 2 sh tment of Health a rant: If item 27 i 9000 Franklin Sq Drive Rosedale, MD Franklin Square Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state Signature of Funeral Struge License Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition thrive Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last signed by the attending physician Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 al or Attending Physician: The safter death. filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral E Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0073005 n who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

of Vital Records,

Division

82. Registrar's Signature

sule

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 19^{Day} 2012 2:18 P M Charlotte May Evans May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium 508 Limerick Circle #402 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, **Funeral** 1 - M 2 X F Months Days Hours Min. Country) MD **Director** Nov. 213**-**14**-**2391 a٨ Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State the Medical Examiner must be notified at Director 1 Yes 2 X No Timonium MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 23a or 10e. Street and Number Funeral USA 21093 508 Limerick Circle #402 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) n/a C & P Telephone Co. Clerk Be or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Thalheimer John Lewis Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Limerick Circle #402, Timonium, MD 21093 Richard M. Evans/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 5/24/12 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signatural Timonium, Padonia Rd., the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure. e, or complication ns that caused Approximate heart failure. Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2☐ Fetal death 3☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 **X**No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate _ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16918 York Rd., Hereford, MD Susan Meltzer, M.D.

/ DHMH 17 Rev 7/2009

State Registrar 32. Registrar' Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Troy Edwards State of Maryland / Department of Health and Mental Hygiene 2012 16071 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 19, 2012 Troy Lamawr Edwards Medical Examiner 0817 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center **Bel Air** Harford 5 Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Hours Director Country) Maryland 1 x M 2 F 215-92-2967 34 Nov. 18, 1977 Usual Residence of Decedent A 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Maryland Harford Churchville hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3055 Churchville Road 21028 LISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year Black 1 Yes 2 X No specify: Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I tent of Health and Mental Hygiene.

Int: If item 27 is marked other than "1 is nother traumatic event, the Medical E Baltimore, MD 21215-0036 12 Grounds Keeper State Education 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) BB Henry C. Edwards, Sr. Helen Linda Peaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Edwards / Mother 3055 Churchville Road, Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Rose Hill Svcs, LLC 5-29-2012 Bel Air, Maryland Donation 5 Other Specify 22. Name and Address of Facility McComas Funeral Home, P.A. 21 Signature of Fin eral Service Lice ile 1317 Cokesbury Road, Abingdon, Maryland 21009 Part I. Enter the disease, or come to time that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death e.Cocaine and Heroin Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g927 5-23-12 sm attending physician of or use as the burial -X UNPENDED Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? Š Records, P. 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed certificate has been sector, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 Other this ۵ 1 🗸 Yes Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural unknown 5 Pending 1 Yes 2 X No death. fd 5-19-12 fd 07:28 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City hours after 3 Suicide 6 X Could not be or Town, State) 4601 Anhurst I t A. Churchville, MD. 24 hours a determined Multi-Family Apt. 4 Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 20, 2012 All au 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 31. Date filed (Month, Day, Year) State Registrar

Univir 17 Rev 1/2001 **OCME 2006**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Gayle L. Eiker 16, 2012 9:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Min. (Month, Day, Year) 216-46-6640 **Director** 1 □ M 2 X F 66 Yrs June 25, 1945 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? pe r items 23a (iner must be Funeral 5921 Beach Avenue 20817 United States and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. er than "natural", or ite Armed Forces?

1 Yes 2 No þ 1 X Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Accountant Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot r other traumatic ever မ Karl Eiker Winifred Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Foote / Cousin 6760 Greatnews Lane, Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Moffee) (Name of Moffee) (Name of Crematorium, Inc. 20c. Location - City or Town, State Page 1 Date Department of Important: If it any injury or conce. 1 Burial 2 X Cremation 3 Removal from State May 21, 2012|Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign ture f Meral Senice Licensee M01619 Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebral Vascular Accident disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Diabetes Mellitus 24a. Was an Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy perform death? 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No ဂ္ 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21551 D71517 May 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natalia Maria Vasquez Martinez, M.D. 8600 Old Georgetown Road, Bethesda, MD 20886

DHMH 17 Rev 06-2011

State Registrar

5-16-12;

EIKER, Sale.

32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:54PM hae ame la MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER BURNIE ARUNGEL 6LEN ANNE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min (Month, Day, Year) 218-64-6369 Hours Director 58 1 M 2 X F DEC. 1, 1953 Maryland Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Linthicum 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5940 Linthicum Lane 21090 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Educator PAMELA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Russell Furness Carolyn Lavern Resch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Alan R. Engel / Husband 5940 Linthicum Lane, Linthicum, Maryland 21090 ENGEL, F 20a. Method of Disposition 20b. Place of Disposition (Name of 18, 20c. Location - City or Town, State 1 □ Burial 2 🖾 Cremation 3 □ Removal from State cemetery, crematory or other place) Mav 5 Other (Specify) Metro Crematory, Inc. 4 Donation 2012 Catonsville, Maryland 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., 21. Signal Funeral Hor S.E., Glen Home, P.A. len Burnie, 8 MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) day Medical Due to r as a consequence of): **Examiner** Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury Due to for as a nonsequence of: or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for 5 Other (specify) Pregnant at time of death Month Day Year ed by the a 9 Unknown g Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate has 1 Yes 2 No director, Be 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: 2 1 Deatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after deat Funeral Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 🕊 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29c. License numbe of death (Item 23a) (Type, Print)

MHMH 17 Rev 06-2011

State

Registrar

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OSPI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William W. Ensor, Sr. May 2012 9:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 Sonachan Court Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days Hours Min Mary Land Months 2**15-**28-7207 80 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson MD. 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 **USA** 5 Sonachan Court 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married <u>چ</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.

7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Leonard Ensor Isabel Nicoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Ensor/ Wife 5 Sonachan Court Towson, MD. 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5-24-12 Dulaney Valley Mem. Towson, MD. 21. Signature of Juneral S Ruck Towson Funeral Home 1050 York Rd. Towson, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ -VU9 disease or condition Cancer resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death
Unknown signed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? Director: After this certificate 2 No 1 Yes Yes funeral director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes hours after death. filled in by the 1 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4

Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 **Secutifying Physician:** To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

STI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

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32. Registra is Signature

charles

Black

2 1 2012

31. Date filed (Month, Day, Year,

1)0061199

Suite 4105,

Touson

May 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1100 PM Year Month **Physician** 2012 Carrol Edward Fabula 1 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WERS E If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number Date of Birth (Month, Day, eb. 11 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year. Months Days Hours 1**X** M 2□ F 1923 217-14-2263 89 Feb. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinations by notified at 1 □Yes 2X No Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 USA 323 Chimney Oak Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 □Yes 2 ☐No 21215-0036 Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Communications 10 Punch Hole Operator 18. Mother's Name (First, Middle, Maiden Surname) and 17. Father's Name (First, Middle, Last) Be Julia (unk) Mickel George (unk) Fabula Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 323 Chimney Oak Drive, Joppa, Maryland 21085 <u>Elizabeth Fabula / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Gdn 5-19-12 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. of Funer Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ARPIO menary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FIATAUGALUIA SEGIA 10:15 P.M 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER GUEN BURNIE ANNE ARVNOEL 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) 586-20-4996 Director 1 🗆 M 2 🔀 F 88 08/17/1923 Western Samoa Usual Residence of Decedent show aţ 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 TNo MD Anne Arundel Linthicum Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 314 Silky Oak Court 21090 U.S.A. ral", or items ? death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ within 72 hours after 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗶 No Maryland 21215-0036 1 Yes 2x No Specify. "natural" 3 X Widowed 4 Divorced Completed Year or Dates Samoan the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ahsu Leota Faalua unknown other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 21090 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Mrs. Faalua F. Smith / daughter 314 Silky Oak Court, Linthicum Heights, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 Department of I Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Glen haven Mem. Park | 05/30/2012 Glen Burnie, Maryland 22. Name and Address of Facility 1 21. Signature of Funeral Service Licenses 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on peart failure. List only one cause on each line. Immediate Cause (Final Onset and Death . METASTATIC ADENO CARCINOMA OF GASTROINTESTINA Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on: that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the IF FFMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No į 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed KIDNEY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ npatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined hours after within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

State

29b. Signature and title of certifier

T. Reddy

31. Date filed (Month, Day, Year)

NAY 2 2 2012

D69090

Glen Burnie, Maryland 21061

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 Hospital Drive,

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year T. Finnick Mary 18 May 7:00 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Meadows Nursing Center Glen Arm Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea July 15, Birthplace (State or Foreign Country) **Funeral** 1 M 2 Months Days Min Hours Director 214-24-0170 Yrs 82 1929 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 🙀 No Maryland Baltimore Glen Arm 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, <u>the Medical Examiner must be</u> I Funeral 11630 Glen Arm Road Apt. 252 21057 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Ď ☐ Yes 2 No If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3₩idowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Myers Helena Harmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anna Ptaszynski / Daughter 931B Federal Hill Road Street, Maryland 21154 20b. Place of Disposition (Name of 20a, Method of Disposition May 22, 20c. Location - City or Town, State cemetery, crematory or other place)
Evans_Funeral CHapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2012 Air
22. Name and Address of Facility 21. Signatu Evans Funeral Chapel & Cremation Service-BelAir 3 Newpaort Drive Forest HILL, Maryland 21050 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ whom mase Mone disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or, Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last anding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Unknown ed by the a detached f Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ herek (anonary 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perforn death? hean certificate 1 Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director Be 26. Place of Deat Check only one) examiner?
1 Yes Hospital 2 No Other: ဂ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) After this the funeral Certificate: 27. Mann of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred atural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation Could not be s after deat Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours at To the Funeral D completed filled it Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) Man21,2012 Name and address of person who completed cause of de m 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

2012

Charles

701

32. Registrar's Signature

28a-f show at event, the Medical Examiner must be notified ō 23a within 72 hours after death "natural", or Baltimore, Maryland 21215-0036 al Hygiene. and Mental His marked of permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

1 - State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Frank, Sr. 201 12:43a W. James May Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Westminster Dove House If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Director 216-14-7795 1 X M 2 | F 88 April 29,1924 Maryland Usual Residence of Dece 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2261 Old Westminster Pike 21048 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: 3 ☒ Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Post Office 12 Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Charles Frank Louise Brodie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Falls Road Parkton, MD James W. Frank, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 5/21/12 Pikesville, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee 11824 Reisterstown Road ELINE FUNERAL HOME 21136 Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due t (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director; After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rea. No.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17° 2012 2:00 Рм Mary Kathleen Griffin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Manor Care Towson Baltimore Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours Country Maryland Feb. 29 ^{Year} 1924 220-14-9383 88 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2X No Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? Funeral 21234 13 White Spruce Court United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Ď 1 Never Married 2 Married 2 XNo ☐ Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White Completed 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Underwriter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H

27 is marked of

traumatic ever ൧ Charles Hinton Smallwood Marie Bunn permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 White Spruce Ct., Parkville, Maryland 21234 Sharon Childs / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 XCremation 3 Removal from State 05/19/12 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital 2 🗹 No Other: မ 1 Tyes 4. Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending work? Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI W. erson who completed cause of death (Item 23a) (Type, Print) 204MD2R34

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAY 2 2 2012

12-03796

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oel Harrison G		1- For State	te of Maryla		artment o			Mental		Reg No. 2	012	1608
Physici		Registrar 1. Decedent's Name (First, Middle	,Last)			-			2. Date of De	ath	3. Ti	me of Death
Medical Exam		Joel Harriso	n Gough						Month May 18, 2	Day Yea 2012	f 08	853 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat						ath	4c. County o			
		906 Montrose Avenue				Laurel				Prince G		10:
Funeral Director				7. Age (In yrs. I		If Unde Months		If Under 24	fin.	irth (MM/DD/YYYY	Foreign P	
Director		219-92- 6531	1XM 2 F		38 y	rs.			Oct 2	, 1973	Country)	
BOY		Usual Residence of Decedent 10a, State 10b. County		10c City	Town or Loc	ation					I 10d.	Inside City Limits
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Aaryland 28a-f show	tor	Maryland Princ 10e, Street and Number	e George	3		10f. Zip	Code			10g. Citizen of Wh		
e Mau or 28	Director	906 Montrose Av	ODUA				2070	77		USA		
0036 within 72 hours after death with the Maryland jene. ser thao "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.		11. Marital Status		edent Ever in U	.S. 13. V	Vas Deceder			Specify Yes or N		- American In	dian, Black,
eath v item	Funeral	1 Never Married 2 Mar	rried Armed Fo	rces?	1f	Yes, specify	Cuban, N	Mexican, Pue	rto Rican, etc.)	White	, etc.	
fter d		3 Widowed 4 Divo	rced If Yes, Give Year or Dates:		1	Yes 2	X No	specify:		Specify:	White	
5-0036 led within 72 hours afte Hygene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Speci	fy only highest grad	e completed)	16a. Deced	ent's Usual C	ccupation	n (Give kind o	of work done	16b. Kind of Bu		•
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003 within iene.	Ĕ		5+		Con	munic			(E) 1 M. (1)	County		
15-0 filed v Hygi of other		17. Father's Name (First, Middle, L Dale Gough	.ast)				18		me (First, Middle, Buffingt	Maiden Surname)		
21215-0036 buld be filed within 7 Mental Hygiene. marked other thao	To Be	19a. Informant's Name/Relationshi	in (Type Print)		19b Maili	na Address	(Street a			mber, City or Town	n State Zip (Code)
O & B = 1	-	Dale Gough, Fat										and 21228
ore, MI ss 1 and 2 s of Health a If item 27 her traum		20a. Method of Disposition			Place of Disp	osition (Nam			Date	20c. Location -		
Baltimore, permit. Pages 1 a Department of He Important: It its injury or other ti		1 Burial 2 K Cremation	_	III State	crematory or		rv Ti	ac 05	/24/12	Baltimo	re. Ma	rvland
Baltimo permit. Page: Department o Important: injury or oth		4 Donation 5 Other Spe 21. Signature of Funeral Service L	icensee Thoms	e Great								
Dep Der		Thomas Ly	U.C.	orege	138	CNADD 1 Fre	deri	eral H ck Roa	d Catons	ville, M	D 2122	8
Physician		23a. Part I. Enter the disease, or c failure. List only one cause of		used the death	. Do not enter	the mode of	dying, su	ich as cardia	c or respiratory ar	rest, shock, or hea	art App	proximate Interval tween Onset and
Medical Examiner	8 14	Immediate Cause (Final disease	a. Cardiac									Death
2.701111101		or condition resulting in death) Due to (or as a consequence of): Dilated Biventricular Hypertrophy										
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OX 68760, anth certificate be executed attending physician and or use as the burial - transit	dical	X UNPENDED	d. X AMENDED 2	3a-b,pt	LII,27	per 1	ne ,89	27 5-2	23-12 sm			
Box 68760 death certificate be the attending physical	2	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	utcome of preg	nancy					23d. Date of		
certif anding	ia la	past 12 months?	I I LIVE DI	rth ant at time of de		etal death Other (Speci		Ectopic preg	gnancy	Month	Day	Year
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n of ding Pl		27. Manner of Death 1 X Natural 5 Pendir		of Injury Day,Year)	28b. Time o	rinjury 128	_	at Work? s 2 No	28d. Describe	how injury occurre	ю	
SiOl Atteo death ector:	gţ	Felian	igation	of Injury - At he	ome farm etr	ant factors			28f Location	(Street and Numbe	or Or Pural Po	ute Number City
Division of Vital Records, ral or Atteoding Physiciao: The law requirers after death. *I Director: After this certificate has been silled in by the funeral director, page 2 should be	Certification:	determ	not be	or injury - Activ	ome, jami, su	eet, lactory,	Onice buil	ung, etc.	or Town,		TOT TUILITY	ate reamber, only
Tospit 4 hour 'uoeri		29a. Certifier (Continue Physical Physi	ysician: To the best	of my knowled	ge, death one	urred at the t	ime, date	and place, a	nd due to the cau	se(s) and manner	as stated.	
Division of To the Hospital or Atteoding Ph. within 24 hours after death. To the Fuoeral Director: After t completely filled in by the funeral	Medical		niner: On the basis of	f examination a								e(s)
F.NF.8	₹	29b. Signature and title of certifier	/			29c.	License r	number		29d. Date signe	d (Month, De	ay, Year)
		(arese	Hall	du			O.C.M.	E.		May 19, 20	12	
Holpers		30. Name and address of person w				E CONSTRUCTION OF THE CONTROL OF THE) = 11.5c	MD 04000			
			istant Medical E			utimore S	treet, B	aitimore,	MID 21223			
S Regis	tate trar	31. Date filed (Month, Day, Year)	Denewa 32. Re	gistar's Signatu	ale .							

COME

12-03651 Ruth Goundry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 16081 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 12, 2012 Medical Examiner 1551 hrs Ruth Goundry 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** country DC Months Days Hours Director Feb 23, 1933 79 577-48-6750 1 M 2X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No or items 23a or 28a-f show must be notified at once. MD Calvert altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Heath and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at once. Prince Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Cox Road 20730 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Armed Forces? 2 X No Yes If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: white 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 receptionist healthcare 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 8 Victor Sartwell Ruth Dixon 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Erwine/daughter 3160 Cox Road Chesapeake Beach, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify 21. Sign ture of Funeral Project Joseph Wide, Director ²²Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ure. List only one cause on each line Between Onset and /Medical Death ^aMixed drug(Metoprolol, Citalopram and Diltiazem)Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions If any leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, The law requires that the death certificate be executed and ca AMENDED 23a, 27, 28a-f, per me, g928 6-8-12 sm this certificate has been signed by the attending physician a il director, page 2 should be detached for use as the burial -X UNPENDED Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. á 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Fuoeral Director: After this certific funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 P ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 1 Yes 2 X No subject ingested medications Pending filled in by the fd 5-12-12 fd 1:29 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3160 Cox Rd. Chesapeake Beach, MD. 3 X Suicide 6 Could not be (Specify) Found: Residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 13, 2012 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Doris Grant 5:03 P.M. MAL 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL ROSEDALE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Funeral Hours Director 1 □ M 2**X** F 213-09-7070 October 8, 1919 92 Maryland Usual Residence of Deced show 10a. State at 10h County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Baltimore Edgemere 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 USA 3 Bluecrab Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 XNo If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 X Widowed 4 □ Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ္ပ Mabel Harris Milton Stockett 19a. Informant's Name/Relationship (Type, Print) uge 1 and 2 single 1 and 2 single 1 and 2 single 27 is named any injury or other once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Grant 3 Bluecrab Court, Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory May 21,2012 Baltimore, Maryland 21. Signature of Funeral Service Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE RESPIRATORY disease or condition resulting in death) HOURS Medical Examiner DEMENTIA STAGE Sequentially list conditions. Examine rany, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FFMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year the 9 Unknown Unknown P.O. by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pendina work?
1 Yes 2 No Investigation he Funeral Director: , pletely filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 20,2012 D54702

DHMH 17 Rev 06-2011

Registrar

FRANKLIN

SQUARE DRIVE BALTIMORE, MD.

ddress of person who completed cause of death (Item 23a) (Type, Print)

NOVELLO

MAY 22

9000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mat Month Physician/ 19^{pay} 2012^{rear} 6:05 Dora Greenberg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Pikesville Examiner 4c. County of Death Emeritus Of Pikesville Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Sex 1 ☐ M 2XX Months Days Hours Min. Jahuary 15.1915 PoTand 97 **Director** 152-26-525 Usual Residence of Decedent 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified 1 Yes XX No Randallstown Baltimore Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a c t be n Funeral United States 21133 4003 Carthage Road items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes ZXX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 3 ₩idowed 4 Divorced 1 Yes 2 No Specify Specify: "natural", Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Shirley Millman 17. Father's Name (First, Middle, Last) 2 Samuel Forman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 4003 Carthage Road, Randallstown, Maryland 21133 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Michelle Shrager / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 V Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Star of David Memorial N. Lauderdale, Florida May 23,2012 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licenses 00 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of) neater **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy page 2 funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 🗆 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 2 No 24 hours after death. Funeral Director: A 1 Yes Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

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State Registrar

DHMH 17 Rev 7/2009

(Check

only one 29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

20051552

(Type, Print)
35 Pikesvilleg Maryland

29d. Date signed (Month. Day, Year)

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bernard Napoleon Goulet 8:30 a M Medical 09 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE MEDICAL CENTER ROSEDALE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Hours Min (Month, Day, Year) **Director** 029-28-6600 84 1 X M 2 □ F Jan 15, 1928 Massachusetts show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f MD Parkville Baltimore 1 🗌 Yes 2 💢 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 21234 8820 Walther Blvd Apt. 3305 U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 X Married Black, White, etc. Yes 2 X No Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: il Hygiene. other than "natural", White 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aberdeen Proving Ground 4 years Mathematician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Fernand Goulet Bouchard Lumena and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Peggy A. Goulet (wife) 8820 Walther Blvd Apt. 3305 Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 5/20/2012 Ignatu e of Funer Sice License 22. Name and Address of Facility Schimunek Funeral Home, Inc 9705 Belair Rd Nottingham MD 21236 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e Immediate Cause (Final Ph_asician Onset and Death YPOX EMIA disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events sician and bunal-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: ISe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ or Attending Physician: The law requires that the death in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed page 1 Yes 2 No 1 Yes 2 X No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural 5 Pending injury n 24 hours after death.

Reference Af pleeter; Af pleetely filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical within 24 hor.

To the Fune:
completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

FRANKLIN SQUARE DR. BALTIMORE, MD 21237

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CHUNG, SOON

31. Date filed (Month, Day, Year)

MAY 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jennie Beatrice Gray 4:00 P_M 1 9 May 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year, 228-16-2343 Director 1 □ M 2X F 90 Bandy, Dec.14, 1921 VA ahov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
I itam 27 is marked other than "natural", or itams 23e or 28e-f aho other traumatic avant, the Medical Examble other traumatic avant, the Medical Examble other traumatic avant, the Medical Examble of the country of the Country of the Medical Examble of the Medical Examble of the Country of th 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walter Blvd. Apt. 1215 21234 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joe Brewster Ethel Altizer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Page 1 and 2 shi Department of Health ar Important: If Itam 27 is any injury or other trau once. Carolyn Jourdan-Daughter 1753 Morse Road Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Du Janey Valley 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State May 25, 201 2 Timonium, MD 4 ☐ Aponation 5 ☐ Other (Specify) Memorial Camens 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services of Funeral Service Licensa Newport Drive Forest Hi]] Maryland 21050 23a. P 1 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s lock, or heart failure. List only one cause on each line Interval Between Imm, diate Cause (Final Physician/ discase or condition sulting in death) **PNEUMONIA** Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir attending physician and I for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 or Attanding Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant GRAY 23d. Date of delivery in the past 12 months? Month Day Year To the Hospital or Attanding Physician: The law requires that the dee within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached. Yes 2 X No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 욘 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar JACKIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONES, CRNP

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19^{Day} Physician/ Month W. 2012 Robert Gollan 2:20 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mt. Airy Frederick Kline Hospice House Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days Hours August 22 220-38-169 70 Washington, D.C. 1941 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Kensington 1 Yes 2 XXIVo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 20895 4502 Franklin Street United States ural", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. Specify: White "natural". 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Owner Towing Company and Mental Hygien
7 is marked other tf Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) and and and of Health and triem 27 is marked artraumatic event ဂ္ John R. Gollan Evelyn F. Creamer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Barbara Keim /Sister 10595 Edwardian Lane, New Market, Maryland 21774 Date 23 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. lette Burnie M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, si i n disease or condition resulting in death) emention Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or imjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical P,O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter d be detached for u in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes cate has been si page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? Discase 24a Was an autopsy After this certificate 2 No 1 Yes 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 X No Hospital မှ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred HOUSE 5 Pending iniury Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only on 29b. Signat 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

Thomas

MD X1702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 2 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryla		artment of Heal [.] tificate of Deat			ene g. No. 2 (12	15087	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		FRE	0		2. Day of Death	Pen	Year	3. Time of Death	
-	Medic Examin	al	ELIZA B		アベヒ	4b. City, Town, or Locat	tion of Death	1 ay	4c. County	of Death	0150 M	
	Examili	eı	Seasons Hospice/No		oital	Randallst				timor	e	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,)			ace (State or Foreign	
	Director		214-26-2669 1 □ Usual Residence of Decedent	M 2 X F 78	Yrs.			Nov 21,	1933	Mary	land	
	yland f shored at	ctor	10a. State 10b. County		ity, Town or Lo					10	d. Inside City Limits	
	r 28a	Director	MD 10e. Street and Number	B	altimor	10f. Zip Code		10	Og. Citizen of	Mhat Count	1X Yes 2 No	
	with the 23a c	Funeral	3913 Mountwood Roa	d		21229			USA		.,,	
36 after death v	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	P. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	11	Vas Decedent of Hispanio f Yes, specify Cuban, Mex Yes 2 X No Spe	xican, Puerto F	cify Yes or No- Rican, etc.)		e - America ck, White, e bla	tc.	
215-0	iin 72 hour ie. han "natu s Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I life. Do	ent's Usual Occupation kind of work done during O NOT use retired)		lg	6b. Kind of B		ustry	
121	ed with Hygien Ither th	a)	12 17. Father's Name (First, Middle, Last)	4	lio	ensed pract		(First, Middle, Ma	healt			
lan	l be filk lental l rked o tic eve	10	Stanley Evans Hal	1				ae Berry		5)		
, Mary	d 2 should alth and N 127 is ma er traumat		19a. Informant's Name/Relationship (Type Leslie Johnson/da			ng Address (Street and Ni Mountwood F			oute Number, City or Town, State, Zip Code) timore, MD 21229			
Baltimore, Maryland 21215-0036	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, cren	sition (Name of natory or other place)	D	ate 2	0c. Location	- City or Tov	vn, State	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature Fune 1 Services Icens Ronald	Directo	r S	Name and Address of F tate Anatom altimore, M	y Board D 2120	1 655 W. 1	Balti	more S	Street	
	Physician/		23a. Part Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.			h as cardiac o	respiratory arres	t,		Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death) a.	Pheu D to (or as a consec	quence of):							
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):					-		
	outed nd ransit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				_					
_	cate be executed physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a consec	quence of):							
120	icate by physical phy		d.				-					
Box 68	To the Hospital or Attending Physician: The law lequires that the death certification 24 hours after death. To the Funeral Director: After this certificale has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year	
, P.O.	law requires that the death has keen signed by the atte ge 2 should be detached for	l by Ph	Part II. Other significant conditions cont	ributing to death but not re	esulting in the u	nderlying cause given in	Part I.		d tobacco use contribute to the cause of death?			
ords	keen s should	letec	Name of the Control o					24a. Was an	24b.	Were autop	sy findings available	
Sec	he law	duo:						autopsy perform 1 \sum Yes 2	ed?	prior to con death? 1 🔲 Yes	pipletion of cause of	
tal	ician: The certificale rector, pag	Be	25. Was case referred to predical examiner?	spital:			Death (Check			how	NICO	
ję Vi	Physi r this c eral din	으	1 Yes 2 No	1 ☐ Inpatient 2 ☐	ER/Outpatier 28b. Time of			me 5 Resider			<i>//</i> -C	
o uc	ath. r: Afte	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work? M 1 ☐ Yes	_		,,			
Division of Vital Records,	Hospital or Attending 124 hours after death. Funeral Director: After stely filled in by the funer	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,	
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificale ha completely filled in by the funeral director, gage	Medical	(Check 2 Medical Examine	an: To the best of my known: On the basis of examination of the best of the be	on and/or invest	tigation, in my opinion, dea	ath occurred at	the time, date and	place, and du	e to the cau	se(s) and manner stated.	
	To the within 2 To the I comple		29b. Signature and title of certifier	She		29c. License numb			d. Date signe			
			30. Name and address of person who con	MD 693	m 23a) (Type, F	ent)	Blun	1 alen	Bur	arp	21061	
E	Stat Registra		31. Date filed (Month, Day, Year) MAY 2 2 2012	32. Registrar's Sign	ature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ John Patrick Hanlon, III 2012 1:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign (Month, Day, Year) 212-30-0498 **Director** 1 € M 2 🗆 F 79 02/13/1933 MD Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f MD Harford Bel Air 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Completed by Funeral 21014 USA 1401 Tavistock Ct. items. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. ed other than "natural", or ite event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 8-31-51 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Manufacturing Bethlehem Steel of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) Irene H. Eichelberger 17. Father's Name (First, Middle, Last) ပ္ John Patrick Hanlon, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Tavistock Ct., Bel Air, MD 21014 Patricia Hanlon - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I-Important; If ite any injury or oth 20c. Location - City or Town, State 7 🗌 Cremation 3 🗌 Removal from State n 5 Other (Specify) Parkwood Cemetery 04/22/2012 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd., Bel Air, MD 21014 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 1005722 8/2016 500 Upper Chesapeake Di. Bel Air H. 30. Name and address of person pho completed cause of death (Item 23a) (Type, Print)

Recommon Baccare Sc. MD,

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 13, 2012 1:01 PM M Bessie Hopkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel 355 Dewey Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Director 219-03-4100 1 □ M 2 🗓 F Yrs. Apr 7, 1920 92 Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director must be notified 1 Yes 2X No <u>ANnapoli</u>s MD Anne Arundel or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 355 Dewey Drive , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. "natural", or iten edical Examiner r 11 Marital Status Armed Forces? 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 11 housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clifford Potts Cropper Henrietta Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Hopkins/son 355 Dewey Drive Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Sign page of Funeral Service ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street de, Director Baltimore, MĎ 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Failure Renal disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? chronic urinary tract infection 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 performed? Yes 2 No ours after death.

eral Director: After this certificate filled in by the funeral director, page 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. Niemele 1630 Main 5f, Suite 101 Chester, MO

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2.12 A M M Hock Alleen 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmerc Baltimore, NO harlestown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** 1 □ M 2 🛱 F Months Hours Min 416-22-6972 96 Georgia Jan. 1916 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No Catonsville MD Baltimore 23a or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21228 709 Maiden Choice Lane RG221N or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White, etc. þ 1 ☐ Yes 2 🗷 No If Yes, Give 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kathleen McGarrah Nathan F. Murray of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3750 Jennings Chapel Road; Woodbine, MD 21797 Mary K. Blanchard Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cem. 5/16/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. . Signature of Funeral Service Dicenses 1630 Edmondson Avenue: Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ SCVD Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 20 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hospital or Attending Physician: The law requires Dementa 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 🗙 No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medica 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 29c. License number R082382 Dan M. Butterwood Cano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

MAY 22

Ann M. Butterworth, CRNP 709 Maidenthoce Come Baltimere MD 21228

12-Ch

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arles Heron, Sr.		For State	Iviai yiai i	Cert	ificate of	Death	u.i.u	,,,,,,,,	, ,		. No.	012 1	
Dhysisian		Registrar 1. Decedent's Name (First, Middle,Last)							2. [Date of Death		3. Time of De	1
Physician crical Examine	O 1 D 11 II								Ň	Month Nay 17, 20	12	0711 hrs	<u>. </u>
	4	a. Facility Name (if not institution, give	street and numb	er)	4	b. City, Tov Columb		cation of D	Death		4c. County of Howard	Death	
	L	Gilchrist Hospice	17	Age (In yrs. la	et hidhday)	If Under		If Under 2	24Hrs. 18	. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State	or
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the Notified	5	7025 Longview Road			1			21044	2 / Cassi	fy Yes or No-		S.A. - American Indian, Bla	ack.
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5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	Completed					Delli		R Mother's	Name (F	irst. Middle. M	aiden Surname)		
filed v		7. Father's Name (First, Middle, Last) Raymond F. Heron		Elizabeth Troxe									
	90	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailing	Address	(Street	and Numb	er or Rur	al Route Num	ber, City or Towr	n, State, Zip Code)	
MD ad 2 shoulth and in 27 is	-	Charles R. Heron	(son)	7025	Longv	ew R				vland 210	V ₁ / ₁ City or Town, State	
G, P. I and Healt fitem		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from		Place of Dispos crematory or other	ition (Nam ner place)	e of cem	etery,	L	Date	200. Location -	City of Town, State	
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Baltimore, permit. Pages I as Department of He Important: If ite injury or other to	Ţ	21. Signature of Funeral Service Licer	isee	101050		lame and A 55 Twi			Witz pad	zke Fune Columbia	ral Homes a, Marylar	Inc. id 21045	
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£xaminer		Immediate Cause (Final disease a or condition resulting in death)	Due to (or as a c		_								
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Box 68760, e death certificate be the attending physic red for use as the bur	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th	2 Fe	etal death	3 [Ectopic	pregnand	СУ	Month	Day	Year
ath ce	sici	1 Yes 2 No 9 Unknow	4	int at time of de	eath 5 0	ther (Spec	ify) _						
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Sion ttend death. ctor:	ä	1 Natural 5 Pending 2 ✓ Accident Investiga	tion		nome, farm, stre	et. factory				28f. Location (Street and Numb	per or Rural Route Nu	ımber, City
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death. *A Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 6 Could no determin	ot be		_iving Facilt					or Tourn	State) mery Road, El		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit		4 Homicide 29a. Certifier 1 Certifying Physic	eiem. To the hest	t of my knowle	doe death occi	urred at the	time, da	ate and pla	ice, and c	due to the cau	se(s) and manne	r as stated.	
thin 2-	Medical	one) 2 Medical Examin	er:On the basis of and manner st	of examination	and/or investig	ation, in my	opinion	i, death oc	curred at	the time, date	and place, and	due to the cause(s)	
# 18 # 8	Me	29b. Signature and title of certifier				29		e number			29d. Date sign	ned <i>(Month, Day,</i> Yea 012	"/
		Lemely Buth	ull, mil				O.C.	IVI. □.			10, 2		
OLX		30. Name and a viress person when Pamela E. Southall, MD	o completed caus	se of death (Ite Medical Fx	_{m 23a)} aminer 90	00 W. Ba	altimor	e Street	, Baltin	nore, MD 2	1223		
	ato	and the second		gistrar's Sign	turo A								
Si Regis	ate trar	0 0 004	2 Dener	w B.	par								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

CCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 3 per dr., g927,05/22/2012dhb
ertificate of Death

Reg. No. Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 3. Time 01 D 3:05p Physician/ Holling ar Medical 4a. Facility Name (if not institution, give street and number). 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nonta Age (In yrs. last birthday) If Under 8) Date of Birth 9 Birthplace (State or Foreign Country) **Funeral** Min Hours **Director** 1 M 2 D F Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 No lumbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2104 15A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be al 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau bia, MD 21045 Baltimore, Disposition 20b. Place of Disposition (Name of Location - City or Town, State Page 1 cometery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5-13-2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Greene Puneral INGSL 23a. Part 1. English the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transi 19 attending physician and Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 🗌 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an cate has l prior to completion of cause of death? autopsy perforr 2 M No this certificate 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2 🗹 No 흔 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After injury 5 Pending Natura Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5.14.2012 6 0 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVIILE 20850 emo.1.1.

Registrar
DHMH 17 Rev 06-2011

State

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 2 0 1 2 Physician/ 4:30 pM 14 May Angelina Hirsch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Maryland 1 🗆 M 2 🗓 F **Director** 0 n/a Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location hours after death with the Maryland event, the Medical Examiner must be notified at Director 28a-f 1 X Yes 2 No Baltimore Maryland n/a 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō Funeral 23a USA 21239 1357 E. Northern Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 1 X Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b, Kind of Business Industry be filed within 72 | and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n/a n/a n/a n/a Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Sitaras Elaina Hirsch, IV Robert Harold Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 1357 E. Northern Parkway, Baltimore, MD 21239 Robert & Elaina Hirsch/Parents Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 5/17/2012 Glen Burnie, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 bryan W. Clary 23a. Part 1. // ter th - disease, or complications that car shock or heart ailure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease ir condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjur) anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\bar{X} \) No for Day Pregnant at time of death signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 \square Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an his certificate has bull director, page 2 sl autopsy perform 1 Yes 2 L 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 Mo မ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1/1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi-29c. License number 29d. Date signed (Month. Day, Year) 14 M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIO COKO HOYOShi 31. Date filed (Month, Day, Year) St. Towson. 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

nge

FIRSCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ 4:35 PM Hirsch 2012 May Belicia Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under Funeral (Month, Day, Year) ay 14, 2012 Maryland Days Min. Months 1 🗆 M 2 🗓 F May Director 0 n/a Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Maryland Baltimore n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21239 1357 E. Northern Parkway within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 🗓 No If Yes, Give ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Completed 3 - Widowed 4 - Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Media (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) n/a n/a n/a n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ ΙV Elaina Hirsch, Harold Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1357 E. Northern Parkway, Baltimore, MD 21239 Robert & Elaina Hirsch/Parents Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 Dongtion 5 Other (Spegfty) 5/17/12 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road, Timonium, MD 21093 Service Licensee Clary Bryan W. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Gause Final disease or condition Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 1 ☐ Yes 2 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate has page 2 1 ☐ Yes 2 ☐ No Yes 2 NO 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 npatient 2 ER/Outpatient 3 DOA ျှ this 28c. Injury at work? the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: hin 24 hours after death. the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated сопріете 2 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21204 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, 32. Registrar's Signature State MAY 22 Registrar

Pleas	se Type or Pr								_	ible.		
For State Registrar	State of M	laryland /	-	artment o tificate o				Jiene Reg. No	2	n I	2	1609
Decedent's Name (First, Middle,	Last)						2. Date of Dea	th		01		ne of Death
William	Beck	with		Hi1	liard	, Sr.	Month	17	2	Year 012	5.	57 P M
4a. Facility Name (if not institution,	give street and number)			4b. City, Town	, or Locatio	n of Death			,	of Death		
Upper Chesapeak	e Medical (Center		Bel A		0414			Harf			
5. Social Security Number 246–16–2492	6. Sex 7. A ₀	ge (In yrs. last b		If Under 1 Ye Months Da		ler 24 Hrs. Min.	8. Date of Birth (Month, Day			9. Birth Cour		ate or Foreign
Usual Residence of Decedent	I ALIVI Z L. F	93	Yrs.				10/02	02/1918			N(C
10a. State 10b. County		10c. City, To	own or Loc	cation								le City Limits
MD Harfor	rd	Falls	ton	,								Yes 2 X No
10e. Street and Number				10f. Zip Cod	е					What Cou	ntry?	
411 Merrie Lane	12. Was Decedent	Suprin II C	110 1	21047 Vas Decedent o	f Hispania (Origin? (Spo	oifu Vos or No	U.S				
11. Marital Status1 ☐ Never Married 2 ☒ Marrie	Armed Forces?		13. V	f Yes, specify C	uban, Mexic	can, Puerto I	Rican, etc.)			e - Americ k, White,	American Indian, Vhite, etc.	
3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	. 140	1	Yes 2 🗓	No Spec	ify:			Specify:	Whi	te	
15. Decedent (Specify only highes		10	6a. Deced	ient's Usual Oct	cupation	ast of warki	na [usiness/In		
Elementary/Secondary (0-12)	College (1-4 or	5+)	life. Do	ONOT use retir ector	ed)		Y		ingh isid		e Aer	ospace
17. Father's Name (First, Middle, La	L Z		шар	ector	18 Mc	thor's Name	e (First, Middle, I					
Richard	Freema	n	Н	illiard			Elna	vialueri	Jamame	,	ckwi	th
19a. Informant's Name/Relationshi	p (Type, Print)	1	9b. Mailin	ng Address (Stre	et and Nun	nber or Rura	l Route Number,	City or	Town, S	tate, Zip	Code)	
Miriam A. Hill:	iard, Wife		411	Merrie	Lane,	Fall:	ston, M	21	047			
20a. Method of Disposition 1		ceme	etery, cren	sition (Name of natory or other p		i	Date 1 /0010			City or To		е
4 Donation 5 Other (Sp		Highv		Memoria		i	1/2012	гал	ıst	on, M	עו	
21. Signature of Funeral Service Lie	al Blan	~	53		ord R	oad,	Leonar Baltimor	re,	MD 2	ick 21214	Inc.	
23a. Part 1. Enter the disease, or o shock, or heart failure. List or			o not ente	er the mode of o	lying, such	as cardiac o	r respiratory arre	est,				Between
Immediate Cause (Final disease or condition resulting in death)	a	SEP								_	Onset a	and Death
roodking in doddiny	Due to (or as	a consequenc	,		. 0.0-	-1.2	. 1					1
Sequentially list conditions, if any, leading to immediate	b. —	Due to (or as a consequence of):								_		
Cause (Disease or injury												
that initiated events resulting in death) Last	Due to (or as	Due to (or as a consequence of):										
•	d											
IF FEMALE:	T											
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal de	eath 3 🗆	Ectopic pregn Other (specify					23d. Da Mo	te of deliv	ery Day	Year
Part II. Other significant condition	_	but not resultin	ng in the u	nderlying cause	given in Pa	art I.	23e. Did to	bacco u	ise conti	ribute to t	he cause	of death?
PROS	7478 C	AH CO	K.	_			1 □ Y	es 2	No	3 🗌 Pro	bably 4	Unknown
							24a. Was a		24b.	Were auto	psy findir	ngs available of cause of
							autop: perfor	med?/	1	death?	_	
25. Was case referred to medical				26	. Place of D	eath (Check		_ de_ 1V(-1			
examiner? 1 Yes 2 No	Hospital:	ient 2 🗆 ER/	Outpatien	nt 3 🗆 DOA	Other: 4 🗌	Nursing Ho	me 5 🗆 Resid	ence 6	Othe	er (Specif	/)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga	ation	ury 28t sy, Year)	o. Time of injury	W	njury at ork? Yes 2	!	28d. Describe ho	ow injury	y occurr	ed		
3 ☐ Suicide 6 ☐ Could n 4 ☐ Hornicide determin	28e. Place of In	290 Diseased Injury. At home form street feature office.							l Route N	umber,		

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial inversi director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Medical

Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1 - For State Registra

29a. Certifier

(Check

29b. Signature and title of cer

Physician/

Medical

Examiner

Funeral

Director

28a-f show

items 23a or 28a-f sho her must be notified at with the Maryland

Completed by Funeral Director

Be

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> Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
>
> Certifying Yurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

> > MAY

MD

2012

20062239. PHYSIC IAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28. MAW N- OO

CHEASAPEAKE UPPER. HOSPITAL,

State Registrar 31. Date filed (Month, Day, Year) **MAY 2 2 2012**

32. Registrar's Signature

ATTENDING

Please Type or Print in Black Indelible ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month K. Howell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SHEPPARD PRATT HOSPITAL TOWSON, MD BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 15-60-4365 Hours Min. Director 1 🗆 M 2 🗙 F 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Perryville 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral anthouse Dr. 04903 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black White etc. 1 Yes 2 If Yes, Give Year or Dates ō <u>6</u> 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) 3urs College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide ည Department of Health and Important: If item 27 is n any injury or other traumone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perryville, MD 21903 Howell 20b. Place of Disposition Wame of 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Randalls town, ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. North Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HYPERTENSION - CARDIOPULMONARY Medical Due to (or as a consequence of): Examiner Years Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 1 YORA SEIZUNE DISONDER ossible that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown - CHRONIC PAIN 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No certificate has 2 Z/No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 3 U Suiciae 4 U Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2 20019332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHEPPRIND PROTT 6501 N. CHARLES ST. TOUSON 21204 DENNIS KUTZER MO () 31. Date filed (Morga, Ay State Registrar A. Sare

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2012 George L. Heselden 18 12:00 A May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Tranquillity of Fredericktowne Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 X M 2 1 Jan 13, New York ∜923 89 Director 096-12-7262 Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "--- any injury or other then the man injury or other the man injury or o 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 XYes 2 No Gaithersburg MD Montgomery 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20878 USA 221 Booth Street Apt 316 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black. White, etc Armed Forces? Completed by 1 Never Married 2 X Married X Yes 2 No 1 ☐ Yes 2 🎦 No If Yes, Give Specify: Year or Dates. 1945-52 3 Widowed 4 Divorced Caucasian 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Telephone Company 5+ Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Blanche Gaffey Thomas Mark Heselden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark G. Heselden / son 14604 Drum Hill Court Gaithersburg, MD 20878 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🗌 Burial 2 🕱 Cremation 3 🗀 Removal from State Final Journey Crematory 5/22/12 4 Donation 5 Other (Specify) Woodbine, MD Signature of Juneral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between set and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director. Hospital: Other: 2 No __ Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the

State Registrar

only one 29b. Signature and title

of certifie

2 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 Physician/ esse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO PARKVILLE OAK CREST CARE CENTER Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 XM 2 □ F **Director** 1-19-1917 MARYLAND 215-09-5368 95 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director 1 Yes 2X No PARKVILLE BALTO. MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21234 USA 8800 WALTHER BLVD. 2415 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No WHITE 1943-1945 Completed 3 ☐√Widowed 4 ☐ Divorced other traumatic event, the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) BUYER MONTGOMERY WARDS 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ HELEN R. ANDERSON SAMUEL F. HOUSE of Health and Nitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DTR. 2311 CARLO ROAD FALLSTON, MD. 21047 DIANE FORD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 5-23-2012 PARKVILLE, MD. PARKWOOD SCHIMUNEK FUNERAL HOME, INC. 21. Signature of run eral Service L 22. Name and Address of Facility NOTTINGHAM, MD. 21236 9705 BELAIR ROAD Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 1. Enter the dise 23a. Part shock, or heart failu only one cause on each line Immediate Cause (Final neumshio Physician/ disease or condition resulting in death) Medical sequence of): Due to (or as a o **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Does to for each donas deepn To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death een signed by the a rould be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Dnknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an p∘ge 2 s has autopsy perforn Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred s after death.

I Director: After the Certificate: 5 Pending injury 1 Natural Investigation by the Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifi 30. Name and address on person who completed cause of death (Item 800 31. Date filed (Month, Day, Year, 32. Registrar's Signat State MAY 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #State of Maryland / Department of Health and Mental Hygiene

2012 16099

		1- For State Registrar	(Certificate of		Reg. No.	012 1007			
	ysician/ 1. Decedent's Name (First, Middle, Last)					Date of De Month	Day Year	3. Time of Death		
ledical Exami	ner	James	Donya		lines Sr.	May 16,	2012	2050 hrs		
		4a. Facility Name (if not institution, give		41	D. City, Town, or Location	of Death	4c. County of	Death		
		7226 Park Heights Avenue #D Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYY								
Funeral Director					Months Days Hours	Min. O1	08 90	Foreign Country) MD		
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any	H	10a. State 10b. County	10c.	City, Town or Location	n			10d. Inside City Limits		
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Maryland 28a-f show d at once.	용	10e. Street and Number			10f. Zip Code		10g. Citizen of Wha	at Country?		
he M 1 or 2 iffed	Director	7226 Park Heig	hts Ave Ar	ot D	21208		U.S	. A .		
death with the Maryland or items 23a or 28a-f sho must be notified at once.		11. Marital Status	12. Was Decedent Ever	in U.S. 13. Was	Decedent of Hispanic Ori			American Indian, Black,		
death or iten	Funeral	1 X Never Married 2 Married	Armed Forces?		s, specify Cuban, Mexican	i, Puerto Rican, etc.)	White,	etc.		
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5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner			edent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)							
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-00. d with rgiene ther t	ĕ	17. Father's Name (First, Middle, Last	···		Construction 18.Mother	r's Name (First, Middle				
215 e file tal Hy ked o		Tames Lerov Hir	205		Brei	nda White	2			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fahr matie event, the Medical Examiner must be notified at ones	P	James Leroy Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street Number, City or Town, Stre								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		Brenda Hines-Mc	ther					ikesville,		
Fe, s l an f Heal lf iten		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Place of Disposit crematory or othe	ion (Name of cemetery, er place)	Date	20c. Location - 0	City or Town, State		
Baltimore, permit. Pages I an Department of Hes Important: If ite!		4 Donation 5 Other Specify	: 1	Woodla	awn .	5/23/2012	2 Woodl	awn, Md		
Balti permit. Departu Import		21. Signature of Funeral Service Licer	1500	22. Na M a 1	me and Address of Facilit	st				
1	1	23s Part I. Enter the disease, or comp	Strallt	430)O Wabash .	Ave, Balt	imore,	Md 21215 Approximate Interval		
Physician /Medical		failure. List only one cause on e	ach line.		e mode or dying, such as o	cardiac or respiratory a	rrest, shock, or near	Between Onset and Death		
Examiner		Immediate Cause (Final disease a. or condition resulting in death)	Narcotic Int					Deali		
		h	Due to (or as a consequer	100 01).						
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequer	nce of):						
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):			· · · · · · · · · · · · · · · · · · ·			
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760, Establishment of the physician and the burial - transi	Medical	X UNPENDED	AMENDED#1 as 1	noted,23a,	27,28a-f,pei	me,g928 6	5-14-12 sr	n		
760, Icate be a physicia the buria	Me	IF FEMALE:	23c, If yes, outcome of	pregnancy			23d. Date of c	delivery		
	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	-6	I death 3 Ectopi	c pregnancy	nancy Month Day			
Box 68 death certificate attending ed for use as	Physician	1 Yes 2 No 9 Unknow	7	ordeath 5 Oth	er (Specify)					
the ph		Part II. Other significant conditions	contributing to death but	not resulting in the un	derlying cause given in Pa	art I. 23e. Did	tobacco use contrib	oute to the cause of death?		
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tal Receision: The certificate		25. Was case referred to medical			26.Place of Death					
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Division of Vital Records, poists or Attending Physician: The law requirents after death. seral Director. After this certificate has been stilled in by the funeral director, page 2 should I	Certification:	3 Suicide 6 X Could not	be		, factory, office building, e	tc. 28f. Location or Town,	State) 7226 P	r or Rural Route Number, City ark Heights Ave		
fri e ou		4 Homicide determine 29a. Certifier 1 Certified Physics	(Tour	nd:Residen	·	Apt D	Baltimor	re,MD.		
To the Hos within 24 h To the Fur completely	ca	(Check only Certifying Physic	lan: To the best of my kno r:On the basis of examinat	wledge, death occurre tion and/or investigation	ed at the time, date and pl on, in my opinion, death o	ace, and due to the car ccurred at the time, dat	use(s) and manner a e and place, and du	as stated. ue to the cause(s)		
To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number			d (Month, Day, Year)		
		/ Yakalan	111		O.C.M.E.		May 17, 20	12		
4		30. Name and address of person who	completed cause of death	(Item 23a)						
Ψ		-	tant Medical Examir		timore Street, Baltir	more, MD 21223				
S	tate	31. Date filed (Month, Day Year)	32. Registrar's S	gnature	·					
Regis	trar	MAY 2 2 2012	peren p.	gara						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Day2012 Year 10:30 P M 19 Sharon S. Huber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours Days Min (Month, Day, Year) 216-56-4913 Director 1 □ M 2 🗓 F 1951 May 4, Maryland Page 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Heelth end Mental Hyglene. ient: If Item 27 is merked other then "netural", or Items 23e or 28e-f shoi ury or other treumetic event, the Medical Examiner must be nutified. At 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 7 No Baltimore Timonium MD 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12246 Roundwood Road #405 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify Specify: 3 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret E. Gorrick Marvin F. Silver. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12246 Roundwood Road #405: Timonium, MD 21093 Jeffrev G. Huber husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If ite eny injury or ot once. Gremation 3 ☐ F

Other (Specify) 1 Burial 2 1 emation 3 🗌 Removal from State Hilltop Service Corp.: 5/22/2012 Towson, MD 4 Donation 1050 York Road 21. Signature of Furters Survice I 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) my Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be detached for use as the buriel-trensit Hospitel or Attending Physicien: The lew requires thet the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 KNo Month 4 Pregnant Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabretic rephropothy 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an recurrent autopsy 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 A Other (Specify) NO Spice Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar NAY 2 1 2012 32. Registrar's Signature

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANNES

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N. Charles

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2012

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 MAY Month Physician/ **VERNON EUGENE** HODGES 17 10:55AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4900 RIDGE ROAD ROSEDALE BALTIMORE S20126 Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 10-9-1927 8 4Yrs 20-28-4192 VIRGINIA **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director BALTIMORE MD ROSEDALE 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4900 RIDGE ROAD 21237 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married ģ 2 🗌 No Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. WWII WHITE 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO FOTE se retired)

TOOL THE MACHINIST 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) INSTRUMENTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES HODGES ۵ LENA TUCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA HODGES/WIFE 4900 RIDGE ROAD ROSEDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State SACRED HEART OF JESUS CEM 5-26-2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVE ROSEDALE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate erval Between set and Death shock, or heart failure. List only one cause on each li Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** 15 2 Ta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examin Cause (Disease or linjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No or Attending Physician: The law requires that the death Day detached for Month the Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 Yes 2 Al No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred iniury 5 Pending Investigation Accident Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [only one reand title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who co State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ireland Doris Η. 1:00 P M May 2012 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Hours (Month, Day, Year) 216-46-7291 Director 1 M 2 X F 91 Yrs 1920 Oct 29. New Jersey Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 Is marked other than "netural", or items 23e or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Timonium MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21.093 2525 Pot Spring Rd. K107 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No timore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hyglen 7 Is marked other th Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Pegg Albert Holcombe Anna Depertment of Health and Important: If item 27 is m any Injury or other traumaone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Thornapple St. Chevy Chase, MD. 20815 Richard Ireland/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD. 5-21-12 Hilltop Service Co. 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Funeral Ser Rd. Towson. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UTERINE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 ☐ Unknown 9 Unknown or Attending Physicien: The law requires that the of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Mio 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \text{ \text{M}} \text{ Other (Specify) } \text{ HOSPICE} 1 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🔲 No Certificate: 1 X Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 624 hours a 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

1:00

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9400M MAY 2012 Richard S. Jordan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL NES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Director 213-12-2942 1 **X** M 2 □ F 90 Dec 28. 1921 Maryland ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b County 10c. City, Town or Location Director MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4823 Carmella Drive 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 X Married XYes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify: 3 Widowed 4 Divorced white "natural", Completed 42-45 Year or Dates. permit. Page 1 and 2 should be filed within 72 hours peptartment of Health and Mental Hygelee. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) auto worker automotive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Govans Jordan Helen H. Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Jordan/spouse 4823 Carmella Drive Bsltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Truneral Service L. ensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street , Director Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final a Atherosclerotic Cardiovascular Phairian/ disease unknown disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the at d be detached for 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has I 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 2 No ER/Outpatient 3 DOA မ 1 🗌 Inpatient 2 🔊 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f, Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractitioner To the best of my Honles diet the time, deterand class, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058141 Older my May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Caton Avenue Baltimore, MD Z1229 Windie Williams, MD 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1103AM Physician/ Month Edward L. Jaworski Medical 4c_County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WEYL rex 6. Sex If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 184-20-3425 1 🛚 M 2 □ F 85 Director 10/30/1926 Pennsylvania Usual Residence of Decede r 28a-f show notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Dunda1k 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 21222 United States 420 Trappe Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 ☐ Never Married 2 🏋 Married XX Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. other than " ent, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Engineer Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, thooce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward Jaworski (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Trappe Rd. Dundalk, Maryland (Wife) Dorothy Jaworski 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/18/2012 Stanislaus Cem. Baltimore, Maryland St Donation 5 Other (Specify) ature of Funeral Service Lie Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death the 8 g Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No Yes the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 \(\sime\) Yes after death. Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the** I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a),√Type, Print)

√ DHMH 17 Rev 06-2011

State Registrar 12-03805 Robert W. Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death	Reg. No.						
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) Robert W. Jones	2. Date of Death Month Day Year May 18, 2012	3. Time of Death 1504 hrs					
VIEUICAI EXAIIIIIEI	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 0	Death 4c. County of Death						
	Harbor Hospital Center 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	N/A 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth	place (State or					
Funeral Director	577 86 9352 1 M 2 F 53 Yrs. Months Days Hours	Min						
Any .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 X No					
the Maryland a or 28a-f she effice at ouce	Too. Silver and Hamber	10g. Citizen of What Count	ry?					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mental Hygiene. Int: If item 37 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4112 Baltimore Street 21227 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No- 14. Race - America	an Indian, Black,					
or items 23	1 Never Married 2 x Married Armed Forces? If Yes, specify Cuban, Mexican, P							
s after rral", c	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Docupation (Give kin	Specify: White						
72 hour a "natt	Elementary/Secondary (0-12) College (1-4 or 5+)	se retired)						
5-0036 ed within 72 hour gegiene. other than "natu he Medical Exan	12 Grounds Keeper	Glen Have:	n Cemetery					
AD 21215-0036 2 should be filed within 72 hours all n and Mental Hygiene. 27 is marked other than "natural mastic event, the Medical Examin To Be Completed by		orma Miller	an are yet					
212 rould b id Ment is marl tic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Route Number, City or Town, State, eet Baltimore, Mar						
ore, MD ss 1 and 2 sho of Health and If item 27 is her fraumat	Jackie Jones / Wife 4112 Baltimore Str 20a, Method of Disposition (Name of cemetery,	Date 20c. Location - City or T						
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	1 Burial 2 Cremation 3 Removal from State crematory or other place))5/21/2012 Baltimore,	Maryland					
Baltirr permit. Pa Departmet Importan Injury or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Gonce Funeral Service	P.A.					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	hway Baltimore, Mary	land 21225					
Physician Medical	failure. List only one cause on each line.		Between Onset and Death					
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
m im	cause. Enter Underlying Cause (Disease or injury that initiated parents resulting in death). Last Due to (or as a consequence of):							
760, cate be executed physician and the burial - transit	d.							
'60, ate be execut obysician and ne burial - tra	■ MENDED 23a,27,per me,g927 5-23-12 s	23d. Date of delivery						
1876 tificate ing phy as the t	FEMALE: 23c. If yes, outcome of pregnancy 1		ay Year					
). Box 687 the death certific oy the attending I ched for use as the	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)							
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the delical Certification: To Be Completed by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part							
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach entification: To Be Completed by P		1 Yes 2 No 3 Proba	opsy findings available					
Records, (The law requires freate has been significate by page 2 should be Completed		autopsy prior to co	empletion of cause of					
I. The tifficate or, page	25. Was case referred to medical 26.Place of Death (C	1 Yes 2 No 1 Yes	2 No					
Vital ystclau this cert directo	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 ✓ DOA Other 4	Nursing Home 5 Residence 6 Other:						
ding Ph. After ti	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 N	28d. Describe how injury occurred						
Division o spital or Attending tours after death. meral Director: After filled in by the func Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Run	al Route Number, City					
Div Dital or Cral Div	4 Homicide determined (Specify)	or Town, State)						
he Hos in 24 ho he Fun pletely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	e, and due to the cause(s) and manner as state urred at the time, date and place, and due to the	d. cause(s)					
To the Ho within 24 To the Fu completel	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Mon						
18	Card Hallan O.C.M.E.	May 19, 2012						
Tike	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re, MD 21223						
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
	MAY 9 0 2012 Produce 8. Decire							

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bernard Kenneth Klopp Medical 4a. Facility Name (if not institution, give street and number, **Examiner** MEDICAL 50 W CENTER 8. Date of Birth (Month, Day, Year1937 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours Director 176-32-2187 1 🕅 M 2 🗆 F 1927 July 22, 74 Pennsylvania Usual Residence of Deceden show or 28a-f show notified at 10a. State 10c. City, Town or Location with the Maryland Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be n Funeral 21234 2414 Woodcroft Road USA items ? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status "natural", or itel Armed Forces? þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates. 155–58 Specify: Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4 or 5+) 5+ teacher education is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Menta Herbert Warren Klopp Violet Blanche Shutter traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 Woodcroft Road Baltimore, MD Department of Health ar Important: If item 27 is any injury or other traconce. Linda Klopp/spouse Baltimóré, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify, Ronal State Anatomy Baltimore, MD Name and Address of Facility Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi Approximate heart failure. List only one ca Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-trar physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the at the detached for Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No page 2 s Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? P Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider iniury 5 Pending 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 29b. Signature and title of certification 29d. Date signed (Month, Day, Year)

State Registrar person who completed cause of death (Item 23a) (Type, Print)

ABASS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Month Physician/ 18, 7:40 A.M Alexander Kromm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 307G Wyndham Circle Owings Mills Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under **Funeral** 5/18/12012 (Month, Day, Year) Hours 214-24-7304 **1XX**M 2 □ F Director 85 Yrs. Oct. 28, 1927 Virginia Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** 1 Yes 2XXNo MD Baltimore Owings Mills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö er than "natural", or items 23a or the Medical Examiner must be 307G Wyndham Circle 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status rowm Black, White, etc. ò 1 Never Married XX Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. WWII Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Mechanical Engineer Self Employed e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other ir other traumatic event, th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) examples ပ္ Nancy Reed Alexander Kromm, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Klara E. Kromm (Wife) 307G Wyndham Cir., Owings Mills, MD 21117 Baltimore, 20a. Method of Disposition
1 □ Burial 2 X cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o All Faiths Crematory & Chapel 5/21/2012 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funer 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sor heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ teriosc (Marcuascul disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner pue to for se a consequence of, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed attending physician and use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed After this certificate 2 🗆 No 1 Yes 25. Was case referred to medical the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Certificate: To Be 1 X Yes Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending 1 🗌 Yes 2 No hours after death neral Director: A Investigation 6 Could not be Accident filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely within 24 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) irim 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Day Kissner 18, 2012 7:35 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Middle River Baltimore Ivy Hall Social Security Number 8. Date of Birth
(Month, Day, Year)
June 2, 1935 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Hours **Director** 212-32-5593 Yrs 76 Maryland Jun<u>e</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Baltimore Baltimore MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 5 West Elm Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces . or Black, White, etc. ģ 1 Never Married 2X Married ☐ Yes 2☐ No 1 ☐ Yes 2 K No Specify: If Yes. Give than "natural", 3 Widowed 4 Divorced Specify. white Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aerco Accountant should be filed with and Mental Hygien 7 is marked other th 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Joseph Kissner Ursula Margaret Sievers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Ruth Rissner-spouse permit. Page 1 and 2:
Department of Health
Important: If item 27
any injury or other tr West Elm Avenue-Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 【★Cremation 3 ☐ Removal from State Evans Funeral Chapel May 21,2012 and Cremation-Belair 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral (8800 Harford Road Chapel and Cremation -Parkville,Maryland 2123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Cerchonvaren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Non Cause (Disease or iinjury that initiated events resulting in death) Last heal Due to (or as a consequence of): physician s the burial Physician/Medical attending for use as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death g 🗌 Unknown 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 Physician: **Director:** After this certifical in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 118112

State Registrar SHOAIIS

e filed (Month, Day, Year)

32. Registrar's Signature

AY 2 2 2012

August

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MHTHH MD

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

09289

Box

P.O.

Records,

of Vital

Division

821 N. EUTAWST SUITE 308 BALTIMORE MUZILLO

7:30 A.

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between

Onset and Deat months

Day

prior to completion of cause of death?

2 No

1 Tyes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 21, 2012

29d. Date signed (Month, Day, Year)

Year

1 X Yes 2 □ No

Rhode Island

White

Division of Vital Hospital or Attending Physician: Director: After To the Hospital or Att. within 24 hours after de To the Funeral Direct

filled in by

Medical

1 X Natural

2 Accident

3 Suicide 4 Homicide Suicide

29b. Signature and title of certifier

29a. Certifier

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Elhamy D. Eskander, M.D., 501 West 7th Street #1A, Frederick, Maryland 21701 Date filed (Month, 32. Registrar's Signature State NAY 2 2 2012 Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MT

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D48184

Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 17, Grover Neal Kershner 2012 00:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-26-5669 1 💹 M 2 □ F **Director** 83 May 10, 1929 West Virginia Usual Residence of Decedent show 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Harford 1 Yes 2 No Forest Hill 10e. Street and Numbe 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 2709 Rocks Road 21050 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Crew Leader Public Utility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is mediany injury or other. ပ William Snowden Kershner Virginia Elizabeth Good 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma P. Kershner / Wife 2709 Rock Road, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Deponațion 5 Ryther (Specify) Entombrent Bel Air Memorial Gdr. 5-21-2012 Bel Air, Marvland Funera Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of e caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PNEUMONIA ASPIRATION Medical Due to (or as a consequence of): **Examiner** BBSTRUCTION INTESTINAL Sequentially list conditions, Due to for as a consequence on cause. Enter Underlying Cause (Disease or injury that initiated events 5 DAYS. FECAL IMPACTION resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical PARKINSON'S DISEASE attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day the 9 Unknown Unknown signed by t d be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kershinar, Grover ATHERO SCLEROFIC CARDIOVASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending P n 24 hours after death. e Funeral Director, After t oletely filled in by the funer Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nitrus Fractitioner: It the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nitrus Fractitioner: It the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nitrus Fractitioner: It the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nitrus Fractitioner: It the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nitrus Fractitioner: 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTENDING DO0 21207 2012 0/2 PITYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21286 C. VELLA- CAMILLERI MD 5 MID CREST CT. BALTIMORE. FRANZ 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

MAY 2 2 2012

3966

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 Day Physician/ ELEANOR FLORENCE KRUSE MAY 2012 7:13 рМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 216 30 6751 (Month, Day, Year) 05/29/1933 78 Director 1 □ M 2 🖾 F MARYLAND Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the McCical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1317 SPRING AVENUE 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ě Maryland 21215-0036 hours after 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: WHITE If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) CUSTOMER SERVICE BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY WILLUMSEN **ELEANOR** T. should be LUPINEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Importent: If Item 27 is any Injury or other trau WILLIAM KRUSE / HUSBAND 1317 SPRING AVE ROSEDALE. MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY 5/23/12 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Fund al Service Coensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Colon disease or condition resulting in death) Cancel Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> ate has been signe page 2 should be 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral or 27. Mariner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifie 29b. 29d. Date signed (Month, Day, Year) 58303 2012 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) houle CAMMES W) MOEM 6701 State 32. Registrar's Si Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent'ş Ņame (Firşt, Middle, Last) 2 Date of Death Month Physician/ RTDXIT 0105 AM 26 Medical Name (if not institution, give street and number) 4c. County of Death **Examiner** Town or Location of Death TIMOZF 4001 If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 8. Date of Birth **Funeral** 1 📈 M 2 🗆 F Months Hours Min. Feb 17, Mary land **Director** 216-32-0184 76 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location must be notified at Director 1X Yes 2 ☐ No **Baltimore** MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral items 23a USA 21223 1941 W. Booth Street filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: black Specify. "natural", Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) home improvement 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil thment of Health and Mental rtant: If item 27 is marked or jury or other traumatic ew ည Ida Lee John Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Raltimroe, MD 21223 19a. Informant's Name/Relationship (Type, Print) William Lee/cousin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state Ronald Wale State Anatomy Board 655 W. Baltimore Street Director Raltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between et and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list remailions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 17 To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2. No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 12 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending work' 1 🗌 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical ■ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the ca 29b. Signature and title of certifier Day, Year) WAD 101

Registrar
DHMH 17 Rev 7/2009

State

Name

Date filed (Month, Day,

MAY 2

Year

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pleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a,25 per verb. 9927,05/22/2012dhb

Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O L 9:55 AM STEVENSON 201 Medical Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TIMORE 8. Date of Birth (Month, Day, Year) 01/05/47 9. Birthplace (State or Foreign **Funeral** 218-44-8325 65 Maryland **Director** 1 🛣 M 2 🗆 F Usual Residence of Decedent show 10b. County notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Baltimore 1X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code ems 23a or must be r 10a. Citizen of What Country? Funeral 3214 Kentucky Avenue 21213 USA items 2 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and Mental Hygiene.
is marked other than "natural", or iter 11. Marital Status Race - Ámerican Indian, Black, White, etc. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Watkins Security Security Officer 11th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည Unknown Mildred Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn L.Blackwell/friend 3214 Kentucky Ave. Baltimore, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/23/12 Owings Mills Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Jr f Funeral Service Licen ^{22. Name and Address of Facility}Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore Md.21206 the ll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or) that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year ed by the a Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kenal Disease Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law cate has by page 2 s prior to completion of cause of death? autopsy 2 No 2 X No 1 Yes Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To ■Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident
3 Suicide Investigation Could not be 24 hours after dear Funeral Director: 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check To the I within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/13/12 1649405424 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :10 David Montague Lockette Medical 4b. City, Tous, or Location, Belair Facility Name (if not institution, give street and number, or Location of Death 4c. County of Death Examiner Healthand Rehabil 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 V M 2 □ F Months Hours Min Nov. 12,1925 220-26-4756 86 Mary land **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Harford 1 🗌 Yes 2 🖵 No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 500 South Fountain Green Road 21015 **USA** item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death Uppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry (nmn) Lockette Annie E. Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris E. Lockette / Spouse 500 South Fountain Green Road, Bel Air, MD. 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cemation 3 Remova cemetery, crematory or other place) Other (Specify) Bel Air, Maryland onation Air Memorial Gdn. 5-23-2012 22. Name and Address of Facility McComas Funeral Home, P.A. . Sig Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the 9 Unknown P.O. ignificant conditions contributing to de 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed after death. Director: After this certificate 1 🗌 Yes Yes Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes Other 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted cause of death (Item 23a) (Type, Print 1308 Buguess State Registrar

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AMEND TTEM#19b, perFH, G927, 5/22/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month S. Loggins 7:10A M Ruby 6 201 Medical 2 N. 161 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BAltimore INAI HUSPI (A Ĭ. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 60 1 M 2 X F Days Country) Yrs Director 76 215-30-8805 MD 06 07 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 2307 North Dukeland Street 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 5 Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) House Homemaker 2th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ္ Ada Brown George Pitts 19a. Informant's Name/Relationship (Type, Print) Daughter 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 2A, 21215 3918 Baltimore, Md Bridget Loggins-Braxton Wabash Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 5/24/2012 Owings Mills, Md Garrison Forest 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee March F/H West Wabash Ave, Baltimore, Md 21215 300 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heresc HEARI DISERSE leron's Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by It ypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe certificate Yes 2 00 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗍 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending s after death. Accident
Suicide М Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number D0054558 2012 address of pers who completed cause of death (Item 23a) (Type, Print) BAltimore HOSPITAL TRMO 2223 (ES) State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ORETTA Month Day Year MAUBOULES CELIA 2017 MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COLUMBIA COUNTY GENERAL HOWARD COUNTY If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Virginia Jine 17, 1941 217-38-5016 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director event, the Medical Examiner must be notified MD Baltimore 1 Ves 2 No Catonsville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 21228 U.S.A. 104 Egges Lane items ? 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces? 14. Race - American Indian. Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White 3 Widowed WX Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Snauffer LeRoy Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Shirley Coleman (Sister) 3434 Keswick Road Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Atlantic Crematory or other place) 1 Burial 2 XX remation 3 Removal from State 4 Donation 5 Other (Specify) 5/19/2012 Glen Burnie, MD 22. Name and Address of Facility Burgee Henss 3631 Falls Road Balto, MD 212 . Signature of Funeral Service License any in once, -Seitz Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ RESPIRATORY FAILURE ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury UNG CANCER and that initiated events resulting in death) Last -trar Due to (or as a consequence of) attending physician Physician/Medical HYPERKALEMIA P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be d \$ Records, SCIERODERMA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of CARDIOMYOPATHY 24a Was an page 2 s performed death' 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. ☐ Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral E Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Mythile MD

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

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MAY,

17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bertha Physician/ D. 2012 0430 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Hospital Randallstown Baltimore Northwest 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Days (Month, Day, 72 Yrs Director 218-36-8981 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Owings Mills 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Greenmountain U.S.A permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. "Tatural", or items Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 ₩ Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade na Cashier Read Drug Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Davis Alberta Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice McDowell-Daughter Greenmountain Ct, Owings Mills, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) 5/25/2012 Zion Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Signatur of Funeral Service Licensee Ave Baltimore, 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ASCVD Onset and Death Phylian disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No ٩ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PR/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DO07552

Registrar
DHMH 17 Rev 7/2009

State

5401

32. Registrar's Signature

old court Rd Randallstown MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAI

Northwest

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth Calvin E. Monroe 12:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CIT N/A BALTIMOR OF If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 9. Birthplace (State or Foreign 212/44/4165 **Director** 1 🗆 M 2 🗆 F 66 6/5/1945 Usual Residence of Decedent MD ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** N/A Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 1607 Ramblewood Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black. White, etc. Completed by 1 Never Married 2 Married be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 🗀 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland 2121 Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Religion Doctorate Pastor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bowman C. Monroe Josephine E. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh trnent of Health a tant: If item 27 is Carolyn Monroe-Wife 1607 Ramblewood Rd. Baltimore, MD 21239 permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 5/19/2012 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gynnoak, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H-East 1101E. 21202 Ave. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** EmBOLISM MONAR Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury METASTASIS. OSTATE Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signature should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Je 2 s certificate has director, page 2 autopsy performed Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2-No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: I Director: After the funers 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 1 Yes Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) AD 1 mai 2 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month JOSEPH A. MARSHALL Medical MAY 18. 2012 5:09 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST TOWSON BALTO. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 216-18-7838 Director 1 🗚 M 2 🗆 F MARYLAND 7-4-1924 87 Usual Residence of Deceder il Hygiene. I other than "natural", or Items 23a or 28e-f shoʻ vent, the Medical Examiner must be notified at Page 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ent: If Item 27 Is marked other than "natural", or Items 23a or 28e-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director BALTO. BALTIMORE 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8019 LANSDALE ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OPTOMETRY OPTICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER MARSZAL LAURA WITOMSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORI MIZELL DTR. 208 FOX HAVEN COURT REISTERSTOWN, MD. 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of
Importent: If It
any Injury or o 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-21-2012 OAKLAWN CEMETERY BALTO.MD. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON INC. 6224 EASTERN AVENUE BALTO.MD. 21224 23a. Part. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one hause of each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ MAC Medical Due to (or as a consequence of): Examiner Wells Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and if for use as the burlal-transit The law requires that the death certificate be executed LOVS that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? my ocardial infarctions Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2. No **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at al or Attending P s after death. Il Director: After t ed in by the funers 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No UNWITHERED Fall 0300 23 2012 Investigation 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 2019 City or Town, State)
2019 Layscale RC, Baltymore My nome Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 58303 Zeiz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 6701 N. Charles ST TONSON CHARLIES and State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death Physician/ Nilima Mazumder 2012 2:15 May 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12330 Rosslare Ridge Road Unit 107 Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 26, Country) 218-60-7108 (Month, Day, Ye **Director** 83 1 M 2 XF India Usual Residence of Decedent 1928 28a-f show 10a State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No ò 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country?
United States 21093 Funeral 12330 Rosslare Ridge Rd. Unit 107 of America items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. an "natural", or iter Medical Examiner þ 1 Never Married 2 X Married 1 Yes 2 **X** No Maryland 21215-0036 Indian 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) should be filed within 72 in and Mental Hygiene. College (1-4 or 5+) 5+ State of the Administrator Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is mark~any injury or ~** Mrinalini Debchoudhury Nishit Ranjan Debchoudhury traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12330 Rosslare Ridge Rd. Unit 107 Timonium Mr. Bibhuti Mazumder/ spouse Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of May 26, 2012 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral 4 Donation 5 Other (Specify) Chapel- Bel Air Forest Hill, Maryland 21. Signatule of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph. sician/ 5 troke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year signed by the a d be detached for 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law performed? Yes 2- N 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1- Natural 5 Pending injury 2 Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of certifier asm.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar VISHC

DAS

31. Date filed (Month, Day, Year)

210

Station

32. Registrar's Signature

Xas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Dolores Higgins Marshall May 10:25 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maplewood Park Place Bethesda Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs **Funeral** Age (In vrs. last birthday 9. Birthplace (State or Foreign 197-07-3804 Davs Months Hours Director 1 🗆 M 2 🔀 F 94 March 23, 1918|Pennsylvania Usual Residence of Dec 28a-f show at 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland Montgomery 1 Yes 2 No Bethesda 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral with 9707 Old Georgetown Road 20814 USA death v items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give ö þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 🔀 Widowed 4 🗆 Divorced "natural" Completed White Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.

7 is marked other than fraumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည of Health and Ments James Higgins Anna Brigman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Walter Joseph Marshall, Jr./Son 3736 Bloxham, Court, Atlanta, Georgia, 30341 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery May 18, 2012 Silver Spring, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home, Bethesda Chevy Chase, Inc. M01305 Miselette 1562 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Paft 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner End Stage Dementia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year the 9 Unknown 9 Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy after death.

Director: After this certificate I 1 Yes 2 No Yes 2 X No B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural iniury work?
1 Yes 2 No 5 Pending Investigation filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D35791 May 17, 2012 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2 2 2012

DHMH 17 Rev 06-2011

Merlyn K. Vemury, MD 9801 Georgia Avenue, Silver Spring, Maryland 20902

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jenrey Magiove	1- For State Registrar	State of Maryla		ertificate of		a ivientai H		eg. No.	201	2	1612
Physician/ Medical Examine	Decedent's Name (First, Mid	Jeffrey V	Magloy	_		2. Date of Dea Month	Day	Year	3. Time o		
	4a. Facility Name (if not institut	tion, give street and nu	mber)		4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death						
Funeral	Harford Memorial Ho 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	Havre' de G		9 Date of Bi	Harfo		dh - l (0	
Director	216-66-8666	1 M 2 F	56		Months Days		8. Date of Bir	9/1955	Forei	rthplace (Sign ountr) ar	
any	Usual Residence of Decedent 10a. State 10b. County	/	10c. City	, Town or Location	n					10d. Insid	de City Limits
land f show	MD	Harford				Aberdeen				1Y	es 2 🔀 No
the Maryland a or 28a-f sh rified at once	10e. Street and Number 77 Greene Ave				10f. Zip Code	21001	1	0g. Citizen of		intry? SA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2	12. Was Dece Married Armed Fo	edent Ever in U orces?	J.S. 13. Was If Yes	Decedent of Hisp s, specify Cuban,	panic Origin? (Sp Mexican, Puerto	pecify Yes or No Rican, etc.)		ace - Amer /hite, etc.	ican Indian	, Black,
s after or niner n		ivorced If Yes, Give Year			es 2 No			Specia	fy:	White	
2 hour 2 hour 1 watu	15. Decedent's Education (Sp Elementary/Secondary (0-12					on (Give kind of v DO NOT use reti		16b. Kind of	Business/	Industry	
5-0036 ed within 72 hour offsgree. other than "nature Medical Exaute Completed	12				Did No	ot Work			N	I/A	
1215-(I be filed antal Hygurked oth went, the Be Co	17. Father's Name (First, Middle	e, Last) Frank Ma	glov		1	8.Mother's Name		Maiden Surna Annette La	,		_
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Popartment of Health and Mental Hyggene. Important: If item 27 is marked other than njury or other traumatic event, the Medical To Be Comple	19a. Informant's Name/Relation Carol Maglov / Si					and Number or Fost Drive, Bo			own, State	, Zip Code)
Ore, es l and of Heal If iter	20a. Method of Disposition 1 Burial 2 Crematio	n 3 Removal fro	m State	Place of Disposition crematory or other	place)		Date	20c. Locatio			
Iltim	4 Donation 5 Other S 21. Signature of Funeral Service	Specify:		Chesapeake	Crematory ne end Address		7/2012		Beltsvi	lle, MD)
	Dorota Marshall	Doubel	Marsh	cell Ma	ryland Crei	mation Serv				ore, MI	21203
Physician /Medical	23a. Part I. Enter the disease, of failure. List only one cause	e on each line.					r respiratory arre	est, shock, or i	heart	Between	nate Interval
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Morphine Due to (or as a c	e and A consequence of	<u>lprazola</u> f):	m Intox	ication				<u> </u>	Death
ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of	f):				···		ļ	
ted Insit	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of	f):				_	_		_
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transit hysician/Medical Ex	X UNPENDED	d2	20 27 2	00 F		0 (1 10					
60, ate be execut hysician and burial - tra	IF FEMALE:	#1 as	noted putcome of pregr	8a-f, per er me, g9	28 6-8-	12 sm	z sm	22d Data	of delives		
Box 687, death certifics the attending plat for use as the aysician/M	23b. Was decedent pregnant in the past 12 months?	ne 1 Live bir		2 Fetal	_	Ectopic pregnar	псу	Month	of delivery D	ay	Year
), Box 687, the death certification by the attending placed for use as the Physician/M		known 9 Unknow	vn	o Other	(Specify)		who				
s, P.O. signed by the detach d by P	Part II. Other significant condit	contributing to c	death but not re	esulting in the unde	erlying cause giv	en in Part I.		2 No			
rds, require been signaled by leted							24a. Was a				gs available
of Vital Records, P.O. og Physician: The law requires that the farth this certificate has been signed by meral director, page 2 should be deach. TO Be Completed by P.O.	autor perfo									ompletion o	
Vital Rec	25. Was case referred to medica examiner?				-	f Death (Check o	nly one)		1 Yes		
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 but on starte death. The Funeral Director: After this certificate has been signed by the attending physician and phelety filled in by the funeral director, page 2 should be detached for use as the burial - transi lical Certification: To Be Completed by Physician/Medical Existed Certification:	3 Suicide 6 X Coul	d not be 28e. Place of	of Injury - At hore Found at	me, farm, street, fa	actory, office buil		28f. Location (St. or Town, Sta Aberdeer	ate) 218	ber or Rur West	al Route No Belai	mber, City
Divis Divis To the Hospital or A within 24 hours after To the Funeral Dire To the Fu	29a. Certifier 1 Certifying PI	nysician: To the best of	examination an	e, death occurred	at the time, date in my opinion, d	and place, and o	due to the cause	(s) and mann	er as state	d. cause(s)	
To con	29b. Signature and title of certifie	and manner stat	ted.		29c. License r			29d. Date sig			ır)
	Potr Ch	- Mola	Ler.		O.C.M.	E		May 14, 2	:012		
	30. Name and address of person Patricia Aronica-Pollal	MD. Assistan	t Medical E	xaminer 90	0 W. Baltimo	ore Street, Ba	altimore, MD	21223			
State Registrar	31. Date filed (Month, Day Year) NAY 2 2 2012	32. Regis	strar' Signatu	ald							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lillian Mary Mitchell May Month 19^{ay} 2012 8:57am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Woodholme Gardens Assisted Living Pikesville Baltimore Co. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 23, **Funeral** 9. Birthplace (State or Foreign Days Hours 220-05-7554 90 Country) **Director** Ĩ921 MD June Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD 1 Tes 2 X No Baltimore Co. Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 Mt. Wilson Ln. 21208 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White Completed 3X Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Homemaker Own Home Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Louis Wickman Frances Catherine Weiber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i Evelyn Hannah Blake - Sister 118 Nelson Rd, Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 5/23/12 Baltimore, MD 21. Signature Jun ral S rvice Licensee 11824 Reisterstown Rd 22. Name and Address of Facility J. Wayne Osterling Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease shock, or heart failure. Li or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stronly one cause on each line. Interval Between Onset Ind Death Immediate Cause (Final Physician Tike disease or condition resulting in death) Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Day Pregnant at time of death signed by the at d be detached fo Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vascular 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 6 Other (Specify) Other: 4 Nursing Home 5 Residence 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier

within 24 hours after death To the Funeral Director: A Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0061199 ron In 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Svite 4(05, Touson, MO, 21204 16701 MI N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Timothy Paul Ne	ewel	1- For State	State of Maryla	and / Dep	partment ertificate	of Hea			Hygiene	2	01:	2 1612
Physici: Medical Exami		1. Decedent's Name (First, Mid Timothy Pau			-	·			2. Date of Dea Month May 21, 2	ath	3	3. Time of Death 0310 hrs
		4a. Facility Name (if not institute 13 Woodward Court	tion, give street and nu	mber)				on of Dea		4c. County of		50 10 1115
Funeral Director		5. Social Security Number 213-64-4435	_ [7. Age (In yrs.) If Ur Mon	nder 1 Year If U			rth (MM/DD/YYYY	9. Birth	
any		Usual Residence of Decedent 10a. State 10b. County		10c. Cit					03/30	71934	•	
ne Maryland or 28a-f show any fied at once.	Director	Maryland Ann 10e. Street and Number	e Arundel			10f. Z		olis		log. Citizen of Wh		
with the M 18 23a or 2 be notified		13 Woodward C		edent Ever in	U.S. 13.	Was Dece			Specify Yes or No			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		Married Armed Fo	orces? 2 X No	1	If Yes, spe	cify Cuban, Mexic	can, Puert	o Rican, etc.)	White Specify:	, etc.	<i>N</i> hite
136 hin 72 hours e. than "natu dical Exan	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12	College (1-		durin-	g most of w	orking life. DO N	OT use re				·
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle Ralph Raymond	e, Last) Newell	de City Fown or Location Annapolis de Carty of Death Anna Arunde Anna Arunde								
MD 21 nd 2 should alth and Me m 27 is ma	2	19a. Informant's Name/Relation Michael Newel			200	Farm	Lane, C)ueen	stown, N	Maryland	2165	58
Baltimore, Department of Hes Important: If ite		20a. Method of Disposition 1 Burial 2 X Crematic 4 Donation 5 Other S	Specify:	om State	etro C	r other plac remato	e) ory Inc	05/	22/2012	Baltimo	re, l	Maryland
		apoulu	The second	_		299 F:	rederick	Roa	d, Balti	lmore, Ma	arvla	and 21228
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	e on each line. _{e a.} Contact Gui	nshot Wou	ınd of Che		or dying, such a	s cardiac (or respiratory arr	est, shock, or hea	n	Between Onset and
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uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	С.	consequence	of):							
50, te be executed sysician and burial - transit	Medical	UNPENDED IF FEMALE:	AMENDED	utcome of pro	ananav		-			024 0-4-4		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		23b. Was decedent pregnant in to past 12 months?	the 1 Live bir	rth ant at time of d	2			pic pregna	ancy		•	Year
ords, P.O. Bo aw requires that the dear as been signed by the at 2 should be detached for	2	Part II. Other significant condi	tions contributing to	death but not	resulting in th	e underlyin	ng cause given in	Part I.			_	
Division of Vital Records, rat or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed								autop perfor 1 V Yes	sy pri m <u>ed</u> ? de	ior to comeath?	pletion of cause of
Vital hysician: this certiful director.	a e e	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital:	patient 2	ER/Outpatie	ent 3 🗍 I	Other			Residence 6	Other: So	cene
sion of Vi trending Physi death. ctor: After this y the funeral dir	ation:	27 Manner of Death 28a Date of Jointy 28b Time of Jointy 28a Joint of World									d	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide dete	ermined (Specify)	Residence	е				or Town, S 13 Woodward	tate) Court, Annapol	is, MD	Route Number, City
To the He within 24 Fo the Fu	'G	(Check only	thysician: To the best aminer: On the basis of and manner sta	examination a	dge, death oc and/or investi	curred at th gation, in m	e time, date and ny opinion, death	place, and occurred a	I due to the cause at the time, date a	e(s) and manner a and place, and du	as stated. e to the ca	ause(s)
DEM	2	29b. Signature and title of certific	er .			29	O.C.M.E.	er		29d. Date signed May 21, 201		Day, Year)
יעי			sistant Medical Ex	xaminer	900 W. Ba	altimore :	Street, Baltin	ore, Mi	D 21223			
Sta Registr	te ar	31. Date filed (Month, Day Year) MAY 2 2 201	2 Server	istrar's Signat	parks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16^{Day} Physician/ Month 05 2012 11:45a™ Jose R. Nova Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 03/15/1965 599-40-1423 **Director** 1 ★ M 2 🗆 F Dominican Rep. 47 Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No Charles Indian Head MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20640 7 Dale Drive items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status er than "natural", or ite Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Dominican Rep. If Yes, Give Spe Hispanic Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Services Computer Programmer 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Francisca Nova 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 Dale Drive, Indian Head, MD 20640 Mildred A. Nolasco Nova (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/19/2012 Clinton, MD Crematory 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Phillip A. W

2431 E. Oliver Street, Balt

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 22. Name and Address of Facility Phillip A. Weatherford, F.S. 2431 E. Oliver Street, Baltimore MD 21213 shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pulmonary Embolism Due to (or as a conse juence of): Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of 24a, Was an s certificate has b director, page 2 s autopsy performed?

Yes 2 \[\sum \text{No} \] death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certificate: 28c. Injury at work? 1 \sum Yes 2 \sum No 1 Natural 5 Pending Director: A id in by the f 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my informacy, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Uen, MD resalle D0063703 05/18/12 7600 CARCOLL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYASACH WOK ANOMA PARU, MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year,

MAY 2 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month Physician/ 2012Laura M. Neudecker May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Apr 3, 1934 Days Hours Min. 1 □ M 2 🗓 F Director 78 358-24-0742 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA 6105 Montrose Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black White etc. 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) draftsman Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Watch Hill Lane Gaithersburg, MD 20878 Department of Health a Important: If item 27 is any injury or other tra Doug Neudecker/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 \square Donation 5 X Other (Specify) in state 21. Signature of Funeral Service Licensea and Director

RONald S. Wade Director

State Anatomy Board 655 W.

Baltimore, MD 21201

23. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Physician/ rementi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Records, **Division of Vital** n 24 hours after death.

e Funeral Director: After to the fundamental of the fundamental completed filled in by Hospital To the within 2

28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Doc6 4871 Farh Miner and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20852 Rel 6121 Montrose Mina tazli MD 31. Date filed (Month

Year

1:10 PM M

9. Birthplace (State or Foreign Country) Illinois

white

Approximate Interval Between Onset and Death

Day

Year

10d. Inside City Limits

1 Yes 2 No

DHILL

unk

State Registrar

		1	For State	State of M		/ Depa	artment of l tificate of l	Health a		ental Hyg	iene	2 N 1	2 6 2
			Registrar 1. Decedent's Name (First, Middle	, Last)		061	tineate of t	Jean		2. Date of Deat	eg. No.	201	3. Time of Death
	Physicia Medic	_	Virginia C.							May May	17,	2012	7:40 PM
Œ	Examin	er	4a. Facility Name (if not institution		Ounty		4b. City, Town, o		of Death			oward	
	Funeral		Gilchrist Cen 5. Social Security Number		ge (In yrs. last	birthday)	Columi If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,			place (State or Foreign
	Director		202-18-1813 Usual Residence of Decedent	1 □ M 2 X F	8.	5 Yrs.	IVIOIIIIIS Days	Tiouis		July 23	,		nsylvania
	and show dat	tor	10a. State 10b. County		10c. City, 1	Town or Lo	cation					1	0d. Inside City Limits
	Mary 28a-f notifie	irec		imore		Cato	nsville						1 ☐ Yes 2X No
	vith the 23a or st be r	Funeral Director	10e. Street and Number 713 Maiden Choi	co I ano Ant	t.2207		10f. Zip Code	228		1		of What Cour SA	ntry?
	leath v items er mu	Fune	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Vas Decedent of H	lispanic Orig	gin? (Spec	cify Yes or No-	14. !	Race - Americ Black, White,	
36	after of	þ	1 ☐ Never Married 2 ☐ Mar 3 X Widowed 4 ☐ Divorced	ried 1 Tes 2 Tes 1 Tes 1 Tes 2 Tes 2 Tes 1 Tes 2			☐ Yes 2 XNo			,		cify: Whi	
21215-0036	hours natura dical E	Completed	15. Decede	Year or Dates. nt's Education est grade completed)			lent's Usual Occup		t of workin		16b. Kind o	of Business/In	
121	thin 72 ine. than " ie Mee	omo	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. D	ome Make:		t OF WORKIN	9	Own	Home	
	led wit Hygie other ent, th	Be	17. Father's Name (First, Middle, I				One Pake		er's Name	(First, Middle, N			
ylan	id be fi Mental arked atic ev	오	Worrall Chand	ler				(Grace	Woodwa	rd		
Maryland	Shoul h and 7 is m traum:		19a. Informant's Name/Relations				ng Address (Street Carillo						1042
	f Healt item 2 other		Lisa Rossberg 20a. Method of Disposition			ce of Dispo	sition (Name of					on - City or To	
imo	Page ment o ant: If ury or		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (\$		C		natory or other pla matory I		05/18	3/12	Balti	more,	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service I	Thomas	Gregor -	2 2	Name and Address remation 99 Frede	Societick	ěty (Road	of Maryl Baltimo	and, re, M	Inc. Jarylan	d 21228
	Physician/	100	23a. Part 1. Enter the disease, of shock, or heart failure. List of Immediate Cause (Final	and the second			4				-	Anu	Approximate Interval Between Onset and Death
•	Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a consequer	nce of):	CANCE	1,00	VEIV	UVV I	01110	7/24	1110101115
	Lxammer	Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	s a consequer	nce of):							
	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с									
_	oe executed ician and burial-transit	<u> </u>	resulting in death) Last	Due to (or as	s a consequer	nce of):							
3760	ficate k g physias the	Medic		u							_		
Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal of at time of dea	death 3	Ectopic pregnan Other (specify)	су			23d	Date of deliv Month	ery Day Year
, P.O.	es that the igned by be detac	by Ph	Part II. Other significant conditi	ons contributing to death	but not result	ing in the ι	ınderlying cause g	iven in Part	I.				ne cause of death?
rds	require been s should	eted								24a. Was a			psy findings available
Seco	he law te has age 2	omo								autops perform 1 Yes	V	prior to co death? 1 \square Yes	mpletion of cause of
Fal	sian; T ertifica ector, p		25. Was case referred to medical examiner?					lace of Dea	th (Check		110		.,
Ţ	Physic this carral dire	요	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa	iury 2 Ef	R/Outpatie	it 3 🗆 DOA			me 5 Reside			HOSPICE
o uc	nding ath. r: After ne fune	icate	1 Matural 5 ☐ Pendi 2 ☐ AccidentInvesti		lay, Year)	injury	wor	k? Yes 2		.ou. Boodingo no	w wholy oo	yan oa	
Division of Vital Records,	or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	28e. Place of Ir	njury - At hom etc. (Specify)	e, farm, str	eet, factory, office		2	28f. Location (St City or Town		mber or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2 Medical I	Physician: To the best of Examiner: On the basis of Nurse Practitioner: To	examination a	and/or inves	tigation, in my opin	ion, death o	ccurred at	the time, date an	d place, and	due to the ca	use(s) and manner stated.
	To the within To the comple	Σ	only one) 3 \square Certifying 29b. Signature and title of certifie		Properties of the								
	Km		30. Name and address of person	who completed cause a	death (Itom 2	3a) /Time !	Print)	645	545	•	WING	1181.	Day, Year) 2012 A;MD 21044
	, 00		DANIEUE	DOBERM	ANIA	10	6336	CE	DAR	CLANE	COL	umbi	9,MD 21044
	Sta Registr		31. Date filed (Month, Day, Year) NAY 2 2 2012	Server 32. Regis	rar's Signatur	Had							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 10:40 PM Lena Price 20% Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1103 Cold Spring Rd. Middle River Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 235 46 4853 1 🗆 M 2 🔀 Director 80 Sept.11,1931 West Virginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 ☐ Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1103 Cold Spring Rd. 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Processor 12 Meat Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy L. Carder Ina Stalnaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter L. Price (Husband) 1103 Cold Spring Rd. Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Bayview Crematory Inc. 5/21/2012 1 Durial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex 21. Signature of Funeral Service License Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exer Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural Accident work? 5 Pending 2 \square No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernice N. Pajtis-Goodwin 4:36 a M 05 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROSEDALE BALTIMORE FRANKLIN SQUARE MEDICAL CENTER 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Months 213 28 9112 Hours 80 **Director** 1 □ M 2 🏝 F May 28,1931 Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I fire Z is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 🗌 Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? GOODWIN, BERNICE 20 Compression Ct. 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces? 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Data Entry Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Krantz Nellie V. Taylor PASTIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Carneal (Daughter) 20 Compression Ct. Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Bayview Crematory Inc. 5/21/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Ser Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, m W. Maryland 21221 23a. It 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last ESRD Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Lunknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of Yes 2 No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🖔 No Other: မ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Yes 2 No 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D00 61667 5/21/2012 MD address of person who completed cause of death (Item 23a) (Type, Print) HANSEN 21237 DR JONATHAN 9000 FRANKLIN SQUARE OR BALTIMORE, MO Day,

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Thomas Persinger 2012 3:18a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death manklin Square Koseda Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Hours **Director** 215-32-7427 1 **X** M 2 □ F 73 December 29,1938 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dundalk Maryland 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 6822 Broening Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. Hersinger John Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. White 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Machine Operator Tech Alloy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Persinger Gladys Persinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Nabbs Creek Road, Glen Burnie, Maryland 21060 Jacqueline Persinger Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 21, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation Bayview Crematory Baltimore, Maryland 2012 Signature of Funeral Service Ja Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami that the death certificate be executed burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical P,O, Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Esophageal Cancer, Anemia, Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 006328 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 Franklin Square Dr. Balto, MD, 21237

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10a-c,e,f,19b,perFH,G928,6/5/2012,WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 910 au William Mads Poulsen Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bel Air Itealth and Rehabilitation Harford Bel Air 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 9, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 🔀 M 2 🗆 F Days Hours T935 Mary Tand Director 213-32-4146 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Pennsylvania Yor Maryland Harford York York 1 Yes 2 No 10e. Street and Number 2760 Pine Grove Road 10f. Zin Code 17403 10g. Citizen of What Country? Funeral $\frac{21085}{21085}$ USA 1527 Stockton Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married ģ XYes 2 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: Hygiene. other than "natural", If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government 12 Soldier 1 and 2 should be filed wit f Health and Mental Hygie item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Bessie Marrian Benny William Mads Poulsen Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1527 Stockton Road, Joppa, Maryland 21085

2760 Pine Grove, York, PA 17403 Doris Metzger Poulsen / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donarion 5 ☐ Other (Specify) cemetery, crematory or other place) Union Chapel U.M. Chr. 5-26-2012 Joppa, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 f Funer Part 1. Enter the disease, or complicated shock, or heart failure. List only one caus erval Between set and Death Immediate Cause (Final -€nysiciaπ/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine to (or as a consequence of): serters, and that initiated events resulting in death) Last to (or as a consequence of) ng physician are as the burial-t Physician/Medical the attending IF FEMALE: 23c. if yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No ☐ Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Troys State 2 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent s Name (First, Middle, Last) 2. Date of Death Physician/ 7:51 PM 201 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard County General Hospital Howard If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) Months Hours Director 119-01-7737 1 ▼ M 2 □ F 90 Sept.14,1921 New York Usual Residence of Deced show 10a. State the Maryland Ħ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Tyes 2 X No MD Howard Columbia 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 5400 Vantage Point Road Apt HC403 21044 USA items ? death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. "natural", or i þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Heatht and Mental Hygiene. Part If item 27 is marked other than "natural", or jury or other traumatic event, the Medical Examiliury or other traumatic event, the Medical Examiliury. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Airline Maintenance Air Line Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rudolph Propper Isabella Goldschmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10144 Spring Pools Lane Columbia, MD 21044 Suzanne Propper Silber/daughter Department of Healt Important: If item 2 any Injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/22/12 Woodbine, MD 21. Signature of neral Service Li Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequance of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the funeral Director. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 🔀 No Yes 2 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Hospita Other: 2 No 1 Yes 1 Inpatient 2 KER/Outpatient 3 I DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Date signed (Month, Day, Year) DO054484 2012

DHMH 17 Rev 06-2011

State Registrar DONAL

31. Date filed (Month, Day, Year)

ederine Coluber MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1,17

5755

a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ e0 Medical 4a Facility Name (if not institution, give street and numbe Examiner LOWING 8. Date of Birth (Month, Day, Year) If Under 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Months 220-20-0508 Pikesville, MD 85 Director 1 □ M 2X F April 11, 1927 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at **Funeral Director** must be notified MD Baltimore Baltimore 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21207 6825 Campfield Rd. Apt. 11E1 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. þ Yes 2 X No Yes, Give permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any njury or other traumatic event, the Medical Examirane. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Photography Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lewis Marshall Fick Naomi Rokel 21207 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6825 Campfield Rd. Apt. 11E1 Baltimore,MD Earl Calvin Peregoy 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 29, Garrison Forest Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) Signatu Evans Funeral Chapel & Cremation Services le, MD 21234 Harford Rd. Parkville, 8800 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, — each line. Approximate Interval Between PSI Onset and Death ediate Cause (Final Physician di ease or condition resulting in death) Medical s a consequence of) to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death signed by the a 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nhknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate Yes 1 Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After to ompletely filled in by the funer. Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title Day, Year) 29d. Date signed (Month, 2012

State Registrar of person who completed cause of ceath (them 23a) (Type, Print)

32. Regist

12-03752
George Pell

PEP Procedure of Health and Mental Hygiene

,		- For State			ertificate of						eg. No.	20		16	
Physicia al Examin	n/	Decedent's Name (First, Midd		George Pe	11					Date of Dea Month May 13, 2	Day 2012	Year	10	e of Deat 56 h rs	ה
		4a. Facility Name (if not instituti Suburban Hospital				b. City, Tov Bethese		cation of D			Мо	ounty of Dea ntgomery			
Funeral Director		5. Social Security Number 213-66-4008	6. Sex		. last birthday)	If Under	1 Year Days	If Under 24 Hours	4Hrs. Min.		rth(MM/DE	9. E Fore	lirthplace Ign Countr ly)		
w any		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Location	on		Bethesd	la			10d. Ins			
with the Maryland ms 23a or 28a-f show be notified at once.	Ø	MD No. Street and Number 7522A Spring Lake 1	Montgomery		_	10f. Zip C		20817	1a		10g. Citize	n of What Co			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	L	11. Marital Status	12. Was D	ecedent Ever in Forces?				nic Origin? Mexican, Pu			D- 14	4. Race - Ame White, etc.			۲,
nours after d	<u>a</u>	15. Decedent's Education (Sp.	vorced If Yes, Give Y or Dates: ecify only highest gr	aar ade completed)	16a. Decedent	's Usual Oc	cupatio	specify:	of wor	k done		pecify: ad of Busines	Whi:		
permit. Pages 1 and 2 should be filed within 72 k Department of Health and Mental Hygiene. Important: If item 27 is marked other than "t injury or other traumatic event, the Medical E	Completed	Elementary/Secondary (0-12 12 17. Father's Name (First, Middle		(1-4 or 5+)		Gove		nt Work		Fede			eral Government		
uld be filed Mental Hyg marked ot	å	19a. Informant's Name/Relation	William	H. Pell	19b. Mailing	18.Mother's Name (First, Middle, Maiden Surname) Raquel Sanchez g Address (Street and Number or Rural Route Number, City or Town,						anchez	ite, Zip C	ode)	
and 2 should and 2 should tealth and 1 item 27 is 1 traumatic	ŀ	Martha Lopez-Na				8331 Wild Cherry Court, Laurel, MD						cation - City	or Town,	State	
it. Pages l urtment of l ortant: If ry or other		1 Burial 2 Crematic 4 Donation 5 Other 5 21. Signature of Funeral Service	Specify:	from State	Chesapeal				5/16	/2012		Belts	ville, I	MD	
nysician	1	Dorota Marshall	ololo	L Un VS								413 Balt	App	MD 2	Inter
Medical xaminer		23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e a Kenal	s a consequence	n	ovasci	ılar	Dise	ase	with	Chro	nic	-	Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):													_	
s be executed sician and burial - transit	dical Ex	d													
certificate nding phy se as the	₽	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 1 Live	s, outcome of pre birth gnant at time of known	2 Fe	tal death ner (Specif	3 [Ectopic pr	egnand	zy		Date of deliving	ery Day	Ye	ar
es that the digned by the	虿	Part II. Other significant cond Angiosarcoma					ause giv	en in Part I				se contribute			
The law requires that rate has been signed bage 2 should be deta	Completed	24a. Was an autopsy performed? 1 ✓ Yes 2								psy orm <u>ed</u> ?				use (
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attention completely filled in by the funeral director, page 2 should be detached for u	To Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Dea	Hospital: 1	Inpatient 2 (Ite of Injury nth, Day, Year)	✓ ER/Outpatient 28b. Time of I	3 00 njury 28	A C	at Work?	lursing 2			ce 6 Ott	her:		
tal or Attend rs after death. al Director: led in by the f	Certification:	1 X Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 1 Yes 2 No 288. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number or Town, State)										er, C			
To the Hospital within 24 hours: To the Funeral completely filled	Medical Co	4 Homicide 29a. Certifier Check only one) 2 Medical Expression 4 Medical	Physician: To the l	is of examination	ledge, death occui n and/or investiga	red at the ti	ime, dat ppinion,	e and place death occur	, and d	ue to the car he time, dat	use(s) and e and plac	manner as s e, and due to	tated.	e(s)	
Tr. William	Me	29b Signature and title of certification	then?	Del 1	1880		License O.C.N	number				ate signed <i>(I</i>	Month, Da	ay, Year)	
	1	30. Name and address of person Victor Weedn MD JI			_{em 23a)} niner 900 W	/ Daltin	C4	root Ball	tim or	MD 21	22				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 12, 2012 2:20 PM_M Physician/ James R. Roe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
St. Mary's **Examiner** Ridge 48409 Smith Drive Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days **Director** 1 X M 2 □ F 78 367-32-6999 Mar 1, 1934 Yrs Michigan Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Yes 2 No St. Mary's Ridge 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Funeral 20680 USA 48409 Smith Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. white "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Heatth and Mental Hygiene. Item 27 is marked other than other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 self employed supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richmond Lockwood Roe Margaret Lorraine Cavan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48409 Smith Drive Ridge, MD Sheri Roe/spouse 20680 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 25 Name and Address of the Board 655 W. Baltimore Street Ronally Service Ronally Diractor Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician Physician/Medical the use as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death been signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 9 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work? 5 Pending 1 Yes 2 No

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the funeral director, after death. Director: Aft within 24 hours after de To the Funeral Directo completely filled in by the

Accident

Suicide

4 Homicide

29a. Certifier (Check

Medical

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

28f. Location (Street and Number or Rural Route Number, City or Town, State)

pleted cause of death (Item 23a) (Type, Print)

Investigation 6 Could not be

determined

40900 Merchants lane Suite 205 Leanardtown MD 20150

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 20, 2012 Physician/ Richert 7:10 Henry AΜ Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Genesis Eldercare - Heritage Center 8. Date of Birth (Month, Day, You February 3 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Days Hours 1**X** M 2 □ F Months Maryland 61 215-50-4439 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21222 11 Centre Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) N/A Never Worked 0 years Be Department of Health and Mental Hill Inportant if frem 27 is marked of any injury or other traumatic conce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Henrietta Huber John Albert Richert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3004 Harview Avenue, Baltimore, Maryland Dennis Albert Richert Sr. Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 23,2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD. Holly Hill Memorial Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Flart 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final ONH Physician/ disease or condition Medical resulting in death) Due to (or as a consequente of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day page 2 should be detached for Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHILDHOOD 1 Yes 2 No Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has performed? Yes 2 1 Ves 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to e ical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred completed filled in by the funeral 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signatule 31. Date filed (Month, Day, Year) 32. Registrar State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 01:15 p^M 05 2012 Ferdinand Reuwer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perry Hall er 1 Year | If Under 24 Hrs. 9405 Kilbride Court **Baltimore** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 X M 2 7 F 216-01-9628 102 10/09/1909 MD Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
sint: If item 27 is marked other than "natural", or items 23a or 28a-f show usy or other than the Page 1 and 1 a 1 ☐ Yes 2 No Director Parkville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21234 8810 Walther Blvd. Calvert Ct. 210 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1929–34 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) AT & T Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reuwer Emma ပ္ Ferdinand 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9405 Kilbride Court Perry Hall, MD 21128 Sharon Ann Reuwer, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \$\overline{\mathbb{X}}\$ Burial 2 □ Cremation 3 □ Removal from State 05/16/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 22. Name and Address of Facility Leonard J. Ruck, 21. Signature of Funeral Service Licensee JBlair Olejandua 5305 Harford Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) nonth **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease on Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs is certificate h 1 □Yes 2 No 1 ☐ Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Daughter's Res. Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? Hospital or Attending 5 ☐ Pending investigation 1 Natural ithin 24 hours after death.

the Funeral Dire tor: Aft

mpletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8400 Blud. andumon 32. Registrar's Signature State 1. parle Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 15, Physician/ George Franklin Rhoads 2012 2:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Senator Bob Hooper House Forest Hill Harford Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral **Director** 211-24-5758 1 XM 2 🗆 F 80 Oct. 26, 1931 Pennsylvania Usual Residence of Decedent or 28a-f show 10b County 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Harford Abinadon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 615 Leight Road 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 ş 1 Never Married 2 X Married XYes Yes, Gi 2 No land 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: "natural" Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Master Craftsman U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I George (nmn) Rhoads Dorothy Mae McComsey Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Rose M. Rhoads / Wife</u> 615 Leight Road, Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of F 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-18-2012 Rose Hill SVCS, LLC Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. of Funeral Service 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CUEBROVISCUAR ACC (DENT) Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) ☐ Yes ∠ L ☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Records, 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 🗌 Yes 1 🗌 Yes 2 🗶 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending work Investigation Could not be 1 Yes 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29d. Date signed (Month, Day, Year) State 2 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 4c,29c per dr., g927,05722/2012dhb Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 125 Physician/ DIBOAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Malti If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday, (Month, Day, Year) 212-38-0081 Director 1 X M 2 🗆 F 83 Maryland Apr 12, 1929 show 10d. Inside City Limits 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 No Keymar Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21757 USA 2080 Francis Scott Key Hwy items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ò Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Hygiene. other than "natural", Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farmer should be filed with and Mental Hygien 7 is marked other ti Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 2 Isaiah Reifsnider Alice Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s 2080 Francis Scott Key Hwy, Keymar, MD 21757 Romaine Reifsnider, wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Grace UCC Cemetery 5/21/2012 Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licenses 136 E Baltimore St, Taneytown, MD 21787 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Day Month Year signed by the at d be detached for 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' the Hospital or Attending Physician: The certificate I 1 Yes Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 es Hospital 2 No ္ခ 1 4mpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how Injury occurred ☐ Natural ☐ Accident injury work? 5 Pending 10PM 9 Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined My cypy of building, etc. (Specify), Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 7335 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month State NAY 22 Registrar

DHMH 17 Rev 06-2011

28a-f show with the Maryland death \ 9 "natural", Baltimore, Maryland permit. Page 1 and 2 should be filed and -trar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 6:10 AM William Richard Rebstock, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arunde1 Glen Burnie Baltimore Washington Medical Center Anne Social Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 216-28-7786 80 Director 1**XX**M 2 □ F 11/18/1931 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10a. State Director 1 ☐ Yes 2XX No MD Millersville Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21108 455 Brightwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2XX No Black, White, etc 1 Never Married XX Married ğ If Yes, Give 1 ☐ Yes XX No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Truck Driver 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rebstock, Sr. Florence Fitzpatrick William R. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millersville, MD 21108 Mrs. Shirley Rebstock / Wife 455 Brightwood Road 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition Date 1 XIXurial 2 Cremation 3 Removal from State Glen Haven Mem. Park! 5/22/2012 Other (Specify) Glen Burnie, MD 4 Donation 5 🗌 22. Name and Address of FacilitySingleton Funeral & Cremation Signa Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 67220 Part Later the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonav Obstructive Immediate Cause (Final Physician/ home disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year page 2 should be detached for Month Pregnant at time of death 5 Other (specify) g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate has 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes Inpatient 2 ER/Outpatient 3 DOA Certificate: To After this filled in by the funeral 27. Mann r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending wor s after death. 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Funel

completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 18,2012 n who completed cause of death (Item 23a) (Type, Print) ^{Year)} 2012 State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 18^{Day} Physician/ May Month 201^Y2^{at} 9:20 Chervl Regensburg-Johns Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) 216-48-7902 Director 1 🗆 M 2 🛣 F 64 Sept. 15 1947 Maryland ir then "naturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11330 Notchcliff Road 21057 U.S.A. 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2x No Black, White, etc. 1 Never Married 2 X Married \$ Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Outdoor Advertising Sales permit. Pege 1 and 2 should be filed Depertment of Heath end Mental Hy Importent: If item 27 is marked oth eny Injury or other treumetic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Rush William Rush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21057 11330 Notchcliff Road Glen Arm, Maryland James Johns / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State HilltopServiceCorp. 5/21/2012 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funda al Burnico House 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E ter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed siclen end burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last ettending physiclen for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed peen Fouluse 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2 No After this certificate has Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: n 24 hours after death.

ne Funerel Director: After this conceptly filled in by the funeral di ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chec 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Signa re and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0071287 5-18-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Shaheeu, 6701 (Y. Choules & F. \$4105, Baltimore, MO \$1204 State Registrar

DHMH 17 Rev 06-2011

12-03572	Please Type or Print in Bla
Addison Nicole Ramsey	State of Maryland / I
1- For State Registrar	
Physician/ 1. Deceden	t's Name (First, Middle,Last)
Medical Examiner	Addison
	Name (if not institution, give street and number) or Hospital

Funeral Director

Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "matural", or items 23a or 28a-f show any
injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medicar Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

	I- For State Registrar 1. Decedent's Name (First, Middle			rtificate o				2. Date of De	Reg. No eath Day	. 2(3. Time of I					
er	4a. Facility Name (if not institution		ison Nic	cole Ka		wn orlo	cation of Deat	May 9, 2	012	c. County o		1100 h	nrs				
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T	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	6. Sex	7. Age (In yrs. I	last birthday)	If Under Months		If Under 24Hr Hours Mir	_	,		Foreig	hplace (Stat					
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Director	10e. Street and Number				10f. Zip C				10g. Ci	tizen of Wh		ntry?					
<u>a</u>	1516 Locust S		cedent Ever in U	I.S. 13. W		1226		Specify Yes or I	10-	U.S.A		can Indian, I	Black,				
Funeral	1 X Never Married 2 Ma						Mexican, Puert			White	, etc.						
ᆰ		orced if Yes, Give Ye or Dates:	ar	1	Yes 2		<u> </u>			Specify:		hite					
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	17. Father's Name (First, Middle,		w Lee Ra	omco:		18.		e (First, Middle									
e l	19a, Informant's Name/Relationsh		м гее к		ng Address	(Street a		Rural Route N	•		n, State	, Zip Code)					
1	Matthew Ramse		er		Locus							land 2	2122				
İ	20a. Method of Disposition	3 Pemoval 6		sition (Name ther place)	of ceme	tery,	Date	200	Location -	City or	Town, State						
	1 X Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 05/17/2012 Baltime											•	-				
	21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A.																
4	23a. Part I. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one card and each line. Approximate Inte																
1	failure. List only one care of each line. Immediate Cause (Final disease a.Sudden Unexplained Death In Infancy												Onset				
-	or condition resulting in death) Due to (or as a consequence of):																
<u>,</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											-					
Examiner	Courte. Enter Underlying Course (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):																
M N	events resulting in death) Last Due to (or as a consequence of): d.																
										-							
	IF FEMALE: 23b. Was decedent pregnant in th		outcome of preg			a [Textonio mano		2	3d. Date of Month	-		Year				
Cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)											Day	real				
J.	1 Yes 2 ✓ No 9 Unknown 9 Unknown												f -1				
2	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco										_	_					
g	24a. Was an									24b. Were autopsy findings availat							
Completed by	autopsy pric performed? dea											completion o	_				
3	1 ✓ Yes 2 No 1 ✓ 25. Was case referred to medical 26. Place of Death (Check only one)												No				
e Re	examiner?	Hospital: 1	Inpatient 2	ER/Outpatier		100	than —	ing Home 5	Resid	tence 6	Other	:					
음	7. Manager of Double 128a Date of Injury 28b Time of Injury 128c Injury at Work? 28d Describe how																
Certification:	Natural 5 Pending Investigation Fd 5-9-12 fd 10:10am 1 Yes 2 No unknown																
Ĕ	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: Residence 28f. Location (Street, factory) or Town, State (Curtis I										LOCU	ist St	umber, (
ပ္မီ	29a, Certifier	nysician: To the be		dge death occ	urred at the ti	ime, date	and place, ar	·			as state	ed.					
G I		miner:On the basis	of examination														
읡	29b. Signature and title of certifie		29c.	29c. License number 29d. I						Date signed (Month, Day, Year)							
Medic	295. Signature and title or certific		(M. O.C.M.E.									E. May 10, 2012					
Medical	255. Signature and title of certifie		/m	7		O.C.M.	.E.		Ma	ay 10, 20	12						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death May Month Physician/ 201ž 3:40 Рм Eileen A. Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Baltimore Oak Crest 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month Day, Year) V• 26, 1932 Country) 1 □ M 2 🔽 F 212-30-6467 79 Maryland Nov. Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Baltimore Parkville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8820 Walther Blvd. USA #RG109 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Catherine Noha William Joyce UBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suite 500; Towson, MD 21204 W. Pennsylvania Ave. Clifford Robinson son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5/31/2012 Arlington National Arlington, VA 4 Donation 1050 York Road 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease, or complications, or heart failure. List only on-Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): nding physician use as the burial Physician/Medical The law requires that the death certificate be Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Dav Pregnant at time of death the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nhknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a. Was an autopsy performed? Yes No has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Cartifying Nurse Fractioner: To the best of my knowledge, death 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) WALTHER BIND PARKVILLE, MD 2123 State

DHMH 17 Rev 7/2009

Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 5:20 PM **Physician** LUBA KAD 2012 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/AJohns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 1 2 / 1 2 / 1 9 2 3 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days 216-78-1808 88 Yrs. UKRAINE Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 X Yes 2 □ No Directo N/A MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? ō 23a 623 S. ROBINSON STREET 21224 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ò If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 2 Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of BASIL AFTAMINSKY MARIA TAMINSKY ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health MARIA RAD/ DAUGHTER 3130 FOSTER AVENUE, BALTIMORE, MD timore, 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 MICHAEL'S UKRL 5/21/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Service Licensee nd Address of Facili & ZEIL EASTERN R INC FUNERAL HOME AVENUE, BALTIMORE, MD 901 21231 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS 12 hours **Physician** /Medical Due to (or as a consequence of): **Examiner** 3 days TRACT INFECTION URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) d by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 **X** No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 1 Inpatient 5 Residence 6 Other (Specify) ၉ s after death.

I Director: After this of in by the funeral d this 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural M 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours af

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 May 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUJAY PATHAK, 4940 Eastern Avenue, Baltimore, MD, 21224 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

T DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2012 Medical Ma Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign Days Hours 223-42-9395 Country) Director 1 XM 2 F 76 April 9,1936 Virginia item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Methoal Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1807 Portship Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?
12 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 75 ment of Health and Mental Hygiene, ant: If item 27 is marked other than United States Postal Elementary/Secondary (0-12) College (1-4 or 5+) 8 years Letter Carrier Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Shaver Edna Mae Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erika Shaver wife 1807 Portship Road, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ò 1 X Burial 2 Cremation 3 Removal from State Department of important: If any injury or once. Gardens of Faith Cem. 4 Donation 5 Other (Specify) Rosedale, Maryland 2012 gnature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part 1. Enter the disease. Part 1. Enter the disease, of co shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician PNBabre disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) 1 A Yes Certificate: To 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work?
1 Yes 2 No 5 Pending after death Investigation M filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tran れいかり 800 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6 Per FH G927 5/22/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ Calvin Ε. Skipwith 2012 2 5 Medical 4a. Facility Name (if not institution, give street and number) 4c County of Death
BAHMORE **Examiner** 4b. City, Town, or Location of Death Franklin Square Hospital ROSEDAIC Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 212 78 5791 27 54 Director 1**√** M 2 □ F Oct.271957 MD Usual Residence of Deceden ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD Baltimore Chase 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 12132 Sugarmill Circle 21220 USA , or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ed other than "natural", or ite event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify:Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) American Elementary/Secondary (0-12) College (1-4 or 5+) Construction Infrastructure is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Willie Earl Skipwith Margaret Plummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. Regina Skipwith (wife) 12132 Sugarmill Circle, Chase, Md. 21220 PW 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Balto, Md. Green Mount Crem. May 28,2012 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Signature of Funeral Service Lean ee Preston St. Balto, Md 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Refractory Immediate Cause (Final Metabolic ACIDOSIS Physician/ Devere disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sepsis evere Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transit omorom iseD and Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? Yes 2 X No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No Other: မ 1 Mainpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orive BAltimore, MD Frantin 0 MD 7000 JAVAYE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 2 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 0 Medical acility Name (if not institution, give street and number) Examiner wn, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Director 212-12-2033 1 □ M 2 🔀 F 92 Sept.12,191 MD permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28e-f show my Injury or other treumetic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 🖳 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 E. Preston St. Apt.222 21202 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █\$No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Smith Amy Keene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Dahl (niece) 2 Baldwin Ct. Apt.D Catonsville, Md. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Arbutus Mem.Pk. May23,2012 Balto, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Signature of Fundant Sal 1412 E. PrestonŠt. Balt.

H. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Balto, Md. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physiclen: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 욛 Other: 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signat and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 2012 20 03:10 ам Charlotte Sneeringer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 2414 Kentucky Avenue If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Country) 215-01-3494 Director 1 🗆 M 2 🕱 F MD 12/21/1916 95 Usual Residence of Dece ms 23a or 28a-f show must be notified at 2 should be filed within 72 hours after death with the Maryland that and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show trumatic event, the Medical Examiner must be notifitied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** N/A Baltimore 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21213 2414 Kentucky Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U. S. Army Civilian Employee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Myrtle Turner Nash Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8640 Sandy Plains Road, Baltimore, MD 21222 t of Health Dr. Paul Sneeringer, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ò Department or Important If any injury or once. Dulanev Valley 05/23/2012 Timonium, MD ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one causeach line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to force a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Director; After this certificate has autops 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \(\sum_{\text{Nursing Home}} \) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? iniury 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Md nth, Day, Year 21 State 2 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ GZOA M Year С. Shifflett 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Souce FRANKLIN Rosedale Ltimore Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** Months Hours **Director** 76 226-46-5182 1XX M 2 🗆 F May 26,1935Virginia Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XX No Maryland Baltimore Dunda 1 k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be n Funeral 636 Peach Orchard Lane 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: 3 Widowed XX Divorced Completed White Year or Dates and Mental Hygiene.
is marked other than "natural aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Construction 1st N/A <u>Home Improvement</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 27 is marker James Shifflett Maggie Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Tammy Hobson Middle River, Maryland 21220 7113 Olivia Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evergreen Cemetery 1 Buria 2 ☐ Cremation 3 ☐ Rep 4 Dovation 5 Other (Specify) 5/22/2012 Standardsville, VA Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ airator disease or condition Medical resulting in death) Due to (or a consequence of): **Examiner** R if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifie 29d. Date signed (Month. Day, Year) RESOUDO 5/17/12

5+2

DHMH 17 Rev 06-2011

State Registrar FRANKLIN

Balto mol 21237

DR

Saya

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month Physician/ 2012 18, 1:10 PM Helena M. Scales Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3126 Gracefield Road #122 Silver Spring Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 236-42-5673 Director 1 M 2 XF West Virginia Jan 17, 1931 Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ä Director the Medical Examiner must be notified 1 Yes 2 X No Silver Spring MD Montgomery ö 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral United States 3126 Gracefield Road #122 20904 or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 🗌 Yes 2 🔀 No If Yes, Give à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify. 3 Widowed 4 Divorced Completed Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) Dance Studio 3 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leona Adams George McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Scales III / Husband 3126 Gracefield Rd. #122 Silver Spring, MD 20904 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🕱 Cremation 3 🗀 Removal from Department of Important: If any injury or 4 Donation 5 Other (Specify) Final Journey Crematory 5/22/2012 Woodbine, Maryland 21. Sign were of FuneraryS Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 well 104 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician 3 Cirrhosis of Liver disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): g physician a Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Day Month Year Pregnant at time of death the g Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate Yes 2 X No 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred

State Registrar

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124 hours after death.

e Funeral Director: Af olderly filled in by the fu

within 2. **To the F**complet

Medical

Hospital

1 X Natural

Accident

Suicide

4 Homicide

29a. Certifier

29b. Signature and

Mark Parkhurst

31. Date filed (Month, Day, Year,

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Rd.

32. Registrar's Signature

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License numbe

D24093

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 Yes 2 No

Silver Spring, MD 20904

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ tar Medical Facility Name (if not institution, give street and number Examiner County of Death throne pice 8. Date Date of Birth (Month, Day, Year) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Country) Director 1 ☐ M 2**X**☐ F 58 2-64-8275 54 b2 01 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified Baltimore 1 X Yes 2 No MD NA or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 21230 2409 Westport Street items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc o þ 1X Never Married 2 Married Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 10th grade Press Operator Printing Company na traumatic event, Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Rose Johnson Edward Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Blo8 Greenmead Road, Baltimore, Md 21244 Tamika Owens-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Page 1 Memorial Park 5/26/2012 King Woodlawn, Md 21. Signature of Fu all Service Licens March F/H West 300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician/ breas disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ n the past 12 months?

I ☐ Yes 2 ☐ No for Month Day Year ☐ Pregnant at time of death☐ Unknown signed by the at 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 2 🗆 No 1 Yes Yes or Attending Physician: inpatien funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 05 20^{Day} 201^{Year} 2:20PM Phyllis Grace Swain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Morningside Assisted Living Anne Arundel Hanover If Under 1 Year I If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 216-18-1874 Director 1 □ M 2 🗓 F 88 08/16/1923 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 7715 Overhill Road United States death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. or i 1 Never Married 2 Married Completed by hours after 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced White Year or Dates. nit. Page 1 and 2 should be filed within 72 hours artment of Health and Mental Hygene. ortant: If item 27 is marked other than "naturinjury or other traumatic event, the Medical I injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. **7 is marked other than "**n Department of Elementary/Secondary (0-12) College (1-4 or 5+) Key Punch Operator Motor Vehicles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ashenfelter Andrew Golden Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph C. Swain / Son 1803 Ridgewick Road Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 05/25/2012 | Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY ARTERY yrs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examin the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical Box 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death Year Day the Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, DEPRESSION DEMENZIA, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No 2 No 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Assisted 1 Yes 2 X No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 😿 Other (Specify) Living 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death I Director: A d in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined within 24 hours are
To the Funeral Dir City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 2137 2012 D0054739 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD. SUITE 204 GLEN BURNIE

DHMH 17 Rev 06-2011

State

Registrar

MAY 2 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2012 Deborah Carol Sidman 19 May 12:09 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 59 214-80-2386 **Director** 1 M 2 X F Jun 13, 1952 New York Usual Residence of Deced 28a-f shov at 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits Director notified Sykesville 1 Yes 2 X No Maryland Carroll 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? must be 23a 21784 USA 6227 Long Meadow Drive items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 و م 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white "natural", Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the N/A Disabled 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ever ဂ္ Jean Cohen Murray Sidman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6227 Long Meadow Drive, Sykesville, MD 21784 Sandra Cornett, caregiver 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/24/2012 Sykesville, MD Lake View Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final DEP Onset and Death Physi i n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner KOWE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: for use 23b. Was decedent pregnant s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? Month Day Year 2 No Unknown 9 Unknown signed by uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The law has page performed 2 No 1 Yes Yes 2 N 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No INPATTER မ 1 Inpatient 2 ER/Outpatient 3 DOA this (27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 24 hours after death. Funeral Director: A М 1 Yes 2 No the Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Sigria re and title of certifie 29d. Date signed (Month, Day, Year) 7 30 Name ddress of person State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month GNES SEARS 33 DM 2012 MAY Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death ARBOR HOSPITAL ALTIMOR N/A 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours (Month, Day, Year) 213 34 6328 **Director** 1 🗆 M 2 🕱 F 75 Maryland 11/01/1936 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21225 U.S.A. 4403 Ritchie Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 1Ó Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Robert Jones Mabel Agnes McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Selby / Daughter 4403 Ritchie Highway Baltimore, Maryland 21225 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Glen Haven Mem. Park | 05/24/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 4 L. DURAGO...
21. Signature of Funeral Services 22. Name and Address of Facility Gonce Funeral Service, P.A. UMO 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ARGAN FAIL disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner CHEMIC ROWEL Cause (Disease or injury that initiated events use as the burial-trar signed by the attending physician and Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗀 No Ves filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Marient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

Registrar

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ALTIMORE, MD 2122J

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			aryland / Depa			ental Hygie		10 10150
		State Registrar	Cer	tificate of De	eath		g. No. 20	12 10120
Physicia Medic		1. Decedent's Name (First, Middle, Last) Kather:		2. Date of Death 3. Time of De Month 20, 2012 5:05 P				
Examir	ner	4a. Facility Name (If not institution, give street and number) Heart Homes Assisted Liv	ing	4b. City, Town, or Lo Lint	ocation of Death hicum		4c. County of Ann	Death e Arundel
Funeral	Г	212 20 5765	e (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) g	. Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	93 Yrs.			02/04/1		Maryland
rland f shov d at	ţ	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits
Many 28a-1 notifie	Director	Maryland Anne Arundel	Linthic					1 ☐ Yes 2X No
with the 23a or st be		10e. Street and Number 99 Shortcross Road		10f. Zip Code 21090)	10	g. Citizen of Wha	,
death vitems	Funeral	11. Marital Status 12. Was Decedent E		Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Spec	ify Yes or No-	14. Race -	American Indian,
IN Z IZ 13-0000 filed within 72 hours after death with the Manyland al Hygiene. I other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	d by	1 X Never Married 2 Married 1 Yes 2 X	No	Yes 2 No		licari, cic.,	Specify: W	White, etc. Thite
hours natura dical E	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occupation	on	16	6b. Kind of Busir	ness/Industry
hin 72 ne. than "	omo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	i+) life. DO	kind of work done duri O NOT use retired) Cher	ing most of workin	g	Day Ca	
ed wit Hygie other ent, th	Be C	6th 17. Father's Name (First, Middle, Last)	lea		8. Mother's Name	(First Middle Mai		ir e
d be fil Mental Mental	ည		orge Sautte			Blotten1		
I're, INIAI yiallu ZIZIO-UOOO 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Evelyn Szczeszek / sister	1	g Address (Street and ortcross F				e, Zip Code) 1and 21090
fe, IV		20a. Method of Disposition	20b. Place of Dispos	sition (Name of	-			ty or Town, State
Page 1 nent of ant: If it		1 🕱 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		1 Cemetery $^{ m or\ other\ place)}$	05/24	I		e, Maryland
Daltillor permit, Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee		Name and Address o				ice, P.A. aryland 21225
		23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on and lige					<u> </u>	Approximate
Physician/	, ,	Immediate Cause (Final disease or condition	mentig					Interval Between
/ Medical Examiner		resulting in death)	a consequence of):					7 9 64,5
	Jer.	Sequentially list conditions, if any leading to immediate Due to (or as a	a consequence of):					
d d ansit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events C.						
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ath certifica attending p	W/W	IF FEMALE: 23c. If yes, outcome of the control of t		le. :			23d. Date o	of delivery
Attending Physician: The law requires that the death certificate be executed at death. The death certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	in the past 12 manths? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at	2 Fetal death 3 time of death 5	Other (specify)			Month	· ·
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requires the been signer should be a	ed by					1 🗆 Yes		☐ Probably 4 ☐ Unknown
law requires been be 2 should	Completed					24a. Was an autopsy		e autopsy findings available r to completion of cause of
The lar	Com					performe	d? dea	
ysician: The ysician: The is certificate director, pag	m l	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatie		LOther	of Death (Check of		- (A w. fall
g Phy: er this	e: To	27. Manner of Death 28a. Date of injur		28c. Injury at	4 Nursing Hom	ne 5 Residence Bd. Describe how		Specify) ATJ171 7 U.S.
eath. or: After the fune	ficat	1 Autural 5 Pending (Month, Day, 2 Accident Investigation 3 Suicide 6 Could not be	; Year) injury	M 1 ☐ Yes	s 2 🗆 No			
or Att after d Direct	Certificate	4 Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office	2	8f. Location (Stree City or Town, S		r Rural Route Number,
To the Hospital or Attending Physicial or Attending Physicial of the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of r						
To the H within 24 To the Fi	Me	(Check only one) 2 ☐ Medical Examiner: On the basis of exonly one) 3 ☐ Certifying Nurse Practitioner: To the 29b. Signature and the figure of gertifier	e best of my knowledge,	death occurred at the t	time, date and plac	e, and due to the c	ause(s) and man	ner as stated.
5 ≥ 6 8		Signature and section of the section	Ch	29c. License nu	409Y	290	Date signed (M	fonth, Day, Year)
3		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pi	rint) Macelia	0.1	An. s	(cl.	Richard Malacal
Stat	te	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	Much	7/16	11.01	UT	round, ry, plob
Registra	ar	MATERY MILL CENSUR C.	A alter					

amend #8,per fh,g928 6-11-12 sm
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			For State Registrar	State of Marylan		nent of He cate of De			giene Reg. No.	2012	2 1615
	Physicia Medic		1. Decedent's Name (First, Middle, Las	J. Sch	wah			2. Date of De	ath Day	2017	3. Time of Death
	Examir		4a. Facility Name (if not institution, give	street and number)	4b.		ocation of Death	(7)		SALT i	
1	Funeral Director	Г	5. Social Security Number 6. Se 314 - 72 - 6005	7. Age (In yrs. la		Inder 1 Year Inths Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th . 104	9. Birth	place (State or Foreign
	iland f show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location	0			/		10d. Inside City Limits
	the Mary or 28a-	Funeral Director	10e. Street and Number	IMORE	10	f. Zip Code	KS		10g. Citize	en of What Cou	1 🗆 Yes 2 💢 No
	eath with ems 23a r must b	unera	1928 STRING	TOWN ROA 12. Was Decedent Ever in U.S	<u>d</u> . 13. Was D	2/ ecedent of Hist	152 panic Origin? (Spe	ecify Yes or No-	1/2	USA 4. Race - Ameri	can Indian
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Married 2 M Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	1	specify Cuban, es 2 .No	panic Origin? (Spe , Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
പ്പു ട-14-12 പ്ടാമന Baltimore, Maryland 21215-0036	iin 72 hou e. han "natu e Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)			Usual Occupat f work done du T use retired)	ion ring most of work	ing	16b. Kind	d of Business Ir	ndustry
7:5% Id 21	iled with I Hygien other ti rent, the	Be	17. Father's Name (First, Middle, Last)	2	Home	make	18. Mother's Nam	e (First, Middle,	Maiden Su	Itom	16,
- <i>1</i> 2	ould be f marked marked	မ	Kobert Ne 19a. Informant's Name/Relationship (Ty.	De. Print)	10h Mailing Ad	dross /Street an	Marc ad Number or Rura				212
5-74-7 ore, Ma	and 2 sh Health ar em 27 is ther trau		David M. Sc. 20a. Method of Disposition	humb-Soonse	1928 S	tringt	FOWN /	Ed. Sp	ark	s, MD	21152
imor	Page 1 ament of 1 ant: If its ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ace of Disposition emetery, crematory	or other place	االما	Date 15/12	Fore	ation - City or T	own, State
nució Balti	permit. Depart Import any inj once.		21. Signature of Funeral Service License		22. Nan	ne and Address	of Facility 164		eka.	Monkto	N, MA ZIIII ES-MANKTON
3			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ications that caused the death ie cause on each line.							Approximate Interval Between Onset and Death
inda	Physician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ	ence of):	ical	Conc	Q.T			Chiser and Death
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. Box 68	To the Hospital or Attending Physician : The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Ecto	pic pregnancy er (specify)			23	d. Date of deliv	rery Day Year
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cords	aw requii as been 2 should	Completed by	coloure leide					24a. Was a	an	24b. Were auto	psy findings available
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Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	ပ္	examiner? 1 ☐ Yes 2 X No 27. Manner of Death	flospital: 1 Inpatient 2 I 28a. Date of injury	28b. Time of	Other	4 Nursing Ho				Hospice
sion (Attending death. ctor: Afte y the fun	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) 28e. Place of Injury - At hor	injury M ne farm street fa	work?	es 2 🗆 No	28f. Location (S			I Pouto Number
Divi	pital or / burs after eral Dire filled in b		4 ☐ Homicide determined	building, etc. (Specify)				City or Tow	n, State)		
	the Hos thin 24 ho the Fun mpleted	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or investigation	n, in my opinion, occurred at the ti	death occurred at ime, date and place	the time, date a	nd place, ar	nd due to the ca	use(s) and manner stated
	D wii		29b Signature and title of certifier	.C.M		29c. License n				signed (Month,	
	10		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	184.	¥ 4105	Bal	time	one, M	10 21204
	Stat Registra	е	NAY 2 2. 2012.	32. Resistraries great	ire						1

18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Van Buren Drive, Annapolis, Maryland 21403 20c. Location - City or Town, State Bethesda, Maryland Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 hterval Between nset Jd Death 23d Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 201 npleted cause of death (Item 23a) (Type, Print)

3. Time of Death

AM

7:58

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

1 X Yes 2 No

20ĬZ

State

Registrar

even

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR,G927,5722/2012,WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Schaefer 12:56 p^M Beverly A. 20. 2012 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center 8. Date of Birth (Month, Day, Year Feb 20, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Yrs 213-36-0348 Director 73 Maryland 1939 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it is "teolical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Reisterstown MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Cantata Court 21136 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 Completed by 1 ☐ Yes 2 🔀 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrator Mortgage Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Smith Harry Meehan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Waldorf, MD 20602 Susan Knower Daughter 4792 Piney Church Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 5/25/12 Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ELINE FUNERAL ${\tt HOME}_{\tt Reisterstown}$, MD 21136 Approximate Interval Between Onset and Death Atherosolaistic Immediate Cause (Final COIDAMY Vescala **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending PhysIclan: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Feta! death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify). 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Ýes 1 ☐Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1☐Yes 2☑No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours after e Funeral Direc determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0320082 2 2/2 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Moss 114 Business Drive Reisterstown, MD 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NAY 2 2 2012

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 145 AM. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 110 5th Ave. Glen Burnie SE Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min **Director** 217-56-9464 1 🗶 M 2 🗆 F 61 MD 1 - 18 - 1951"natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21060 110 5th Ave. SE within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 M Married þ ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager Be should be file th and Mental Hv 7 is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rose Unknown Elmer Svoboda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 110 5th Ave SE, Glen Burnie Maryland 21060 Mrs. Linda L. Svoboda/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of Important: If ite any injury or of Burial 2 X Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place, Other (Specify) 05/22/2012 Catonsville, Maryland Metro Crematory ce Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Crain Hwy SE, Glen Burnie, Maryland 21061 421 M01364 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pinset and Boath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and trai Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 phys the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery 1 Live Birth 2 Line and 4 Pregnant at time of death for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year g Unknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has certificate 1 Yes 2 No Yes ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2" No Hospital: Other: ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical within 24 hou

To the Funer

completely fi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif ame and address of person wb death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) SNYDER Month 2008 M 2012 Physician/ ZVELYN Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Glen Burnie 450 Nolcrest Road 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 5. Social Security Number **Funeral** Days Hours Min Country) 8 120-1935 MD 76 1 □ M 2 🕇 F 218-30-5906 Director Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location at 10a State Director Anne Arundel Glen Burnie 1 Yes 2 No must be notified MD 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 21061 23a Funeral 450 Nolcrest Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14 Race - American Indian be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married white Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Mental Hygiene. narked other than " natic event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Home Owner Home maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melba Ward 27 is marked or traumatic eve ည Oliver Byrd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 450 Nolcrest Rd. Glen Burnie MD 21061 William T. Snyder/husband 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Comer (Specify) 5/22/2012 Catonsville MD Metro Crematory injury 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Signature of M01364 421 Crain Highway, SE Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ARUNIC Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Year Month Day in the past 12 months? Pregnant at time of death 2 No Yes been signed by the s should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ${\it eral\ Director}$: After this certificate has filled in by the funeral director, page 2 : 2 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home , Residence 6 Other (Specify) ဂ္ 1 Yes 2 100 Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pendina 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌

State

DHMH 17 Rev 06-2011

Baltimore,

Registrar

only one)

9h_Signature and title of certifie

Name and address of person

31. Date filed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print

D 21438

DEFENSE HWY HANAPOLIS

MD21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Sullivan 2012 12:05 a^M May 21, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 211 Greenspring Valley Drive Owings Mills Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** April 18, 1933 **Director** 004-28-2528 1**X** M 2 □ F 78 |Massachusetts Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Owings Mills 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Greenspring Valley Road 21117 U.S.A. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Examiner 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ 1 XYes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. '54**-**'56 Specify: 3 Widowed 4 Divorced White Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Business Exectutive Steel/Manufacturing Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sullivan Oliver Joseph Dorothy Donnelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Ellen Sullivan-wife 211 Greenspring Valley Road, Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv Corp 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 5/22/12 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 21. Signature of Funeral S ce Licensee William G. Dau 22. Name and Address of Facility Ruck Towson, Funeral 1050 York Rd., Towson, MD 21204 Home, Inc. May Approximate Interval Between Inset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physicum/ INSULINDMA disease or condition resulting in death) mo Medical Due to (or as a consequence of): Examiner PANCREATIC NEURO ENDOCRINE TUMOR MIETASTATIC Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl Richard IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown Unknown signed by tel Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been signature should be 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 perform 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D55942 ame and address of person who completed cause of death (Item 23a) (Type, Print) St. Sk 203 roster harles State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day Month Year **Physician** 04 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COMMUNITY LIVING CENTEDALLINOR 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 12, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 175-14-7971 89 1922 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 959 Radcliffe Road 21204 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 V Yes 2 No If Yes, Give Year or Dates: 43-45 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medica (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronics Veterans Adminisrtation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Safchuck Julia Szypula 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Yutchishen-sister 7204 Woodrow Avenue, Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1X Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 5/25/12 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serve Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PATO CELLULAY Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? res 2 No Division or Vital Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A HACHMI MD. 3900 Loch RAVEN BOUL VARI BALFO MD 21218 State

DHMH 17 Rev 1/2001

Registrar

Frank J. Sagan, Jr.

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	State of Maryland / Department of Health and Mental Hygiene	201	

rank J. Sagan,	Jr.	State of Maryland / Depart	ment of ficate of	Health	and	Menta	al Hygi	ene	eg. No.	201	2 16161
Physicia Medical Exami		Decedent's Name (First, Middle,Last)							h Day 012	Year	3. Time of Death 1934 hrs
		Baltimore Washingtom Medical Center	4t	Glen Bu	n, or Lo				4c. Cou	inty of Death Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 220 36 6768 1 M 2 F 71	birthday) Yrs.	If Under of Months		If Under 2 Hours	Min	Date of Bird		Foreig	thplace (State or in untry) MD
MD 21215-0036 at 2 should be filed within 72 hours after death with alth and Mental Hygiene. The marked other than "natural", or items 23 aumatic event, the Medical Examiner must be no	To Be Completed by Funeral Director	Florida Palm Beach Palm 10e. Street and Number 245 Foe Dr 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced From Street and Palm 15. Decedent's Education (Specify only highest grade completed) 16. Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Frank Joseph 19a. Informant's Name/Relationship (Type, Print) Shannon Sagan - Son 20a. Method of Disposition 20b. Place	13. Was If Yes 1 Yes 1 Yes during mos	Decedent of specify Cores 2 X Usual Oct of workin Viso Standaress (Cores Donn (Name of Same)	No scupation g life. D	Mexican, Properties of the Mother's Norther's	? (Specify uerto Rica d of work e retirad) Name (Firsh Mair or Rural	vyes or No- in, etc.) done st, Middle, M ry W Route Num	14. R V Speci 16b. Kind o US F aiden Surna hite ber, City or	White, etc. If y: V If Business/li Posta ame) Town, State,	can Indian, Black, White Industry Service Zip Code)
Baltimore, permit. Pages I an Department of He Important: If ite		. Daniel 2 A cromaton of temoval nometate	view (Cremand Add	ress of	Facility a D:	GJ G rive	once Pa	Fune saden	eral	Home PA D 21122 Approximate Interval
execu an and	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Multiple Injuries Due to (or as a consequence of): Due to (or as a consequence of): d. 23c. If yes, outcome of pregnance of the pregnant at time of death of the pregnant at time of the pregnant at tim	2 Fetal	death (Specify)	3 🔲	Ectopic pre	egnancy		23d. Date Month	e of delivery n Da	Between Onset and Death Death
Division of Vital Records, P.C. spital or Attending Physician: The law requires that hours after death. Brall Director: After this certificate has been signed! Tilled in by the funeral director, page 2 should be dear	Medical Certification: To Be Completed by	(Month Day Year)	Outpatient 3 b. Time of Inju 27 hrs farm, street, f Home leath occurred r investigation	26.P DOA ry 28c. 1[factory, offi d at the time, in my opin 29c. Lice	Oth Oth Injury at Yes ce build	Death (Che er 4 Nu Work? 2 No ing, etc. and place, ath occurre	eck only oursing Hore 28d. Subj	1 Yes 24a. Was an autops; perform Yes 2 ne) ne 5 R Describe he ect fell do ror Town, Star Forest Gle to the cause ime, date an	esidence 6 w injury occown steps reet and Nurte) en Drive, P s) and mann nd place, and	b. Were autoprior to codeath? 1 Yes Compared Section 1 Other: Surred Section 2 Section 2 Section 2 Section 2 Section 2 Section 3 Section	opsy findings available impletion of cause of 2 No No No No No No No No No No No No No
Sta Registra	te	Patricia Aronica-Pollak MD. Assistant Medical Examusi. 31. Date filed (Month, Day Year)	•		ltimor	e Street	t, Baltim	nore, MD	21223		

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 945 P_M 2. Date of Death Physician/ 2012 Norman Taubenfeld Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Hospital Center Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 212-28-0218 1 X M 2 □ F **Director** 81 Nov 23, 1930 New York Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Tes 2 No Carroll Westminster Maryland 10e. Street and Number 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral 21157 USA 801 Cindy Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give þ 1 Never Married 2 X Married 1947 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 1957 Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Medical Medical Technologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leo Taubenfeld Anna Finn Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Mary Taubenfeld, Wife 801 Cindy Lane Westminster, Maryland 21157 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 \square Burial 2 X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/21/12 Metro Crematory Inc. Baltimore, Maryland Thomas Gregor Chame and Address Stracilly Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ HEMATOMA SUBBURAL disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Day 5 Other (specify) 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case rred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examin ? Hospital 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Accident injury work? 5 Pending motor vehicle accident s after death. 1607 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined WESTMINSTER ROADWAY within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30263 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print)
RANCIS KLUOD MD 'ZOO MEMORIAL AVENUE, WESTMINSTER MD 2115 RANCIS ND MAY 2 2 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 12:30 P M 16, 2012 May Physician/ Jesse Leroy Thomas Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Columbia 4955 Woodward Gardens g. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days Hours **Funeral** 1 ቖ M 2 🗆 F 377-22-2768 Yrs May 23,1928 Oklahoma **Director** 83 Usual Residence of Dece 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County must be notified at Director 1 🗆 Yes 2 🔀 No Columbia Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ö USA 23a Funeral 21044 4955 Woodward Gardens Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n Black, White, etc. African ed Forces? Yes 2 No Armed Fo 1 Never Married 2 Married ģ Yes 2 No Specify: If Yes, Give Year or Dates 1952-54 American 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Education Assistant Professor the 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland Bernice Meadows and Mental F ည Cleo Thomas injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4955 Woodward Gardens Columbia, MD 21044 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ida M. Thomas / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 5/19/12 Woodbine, MD 4 Donation 5 Other (Specify) Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Juneral Service M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final Prostate Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day Month in the past 12 months? or Attending Physician. The law requires that the death for Pregnant at time of death 2 No ed by the a detached f Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed by Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No peen 24a. Was an autopsy has performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 26. Place of Death (Check only one) Be 25. Was case referred to medica Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 XNo ြု 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No injury 5 Pending X Natural Investigation 6 Could not be Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆 29d. Date signed (Month, Day, Year)

Wan (715) 29b. Signature and title of certifie 2012

State Registrar

DHMH 17 Rev 06-2011

Clement Bernard Knight 10710 Charter Drive Suite G020 Columbia,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#10e, f, 17, 19a, 20a-c, 22perFH, G927, 5/22/2012, WS State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5-9 Jacqueline Thomas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 216-50-0792 **Director** 1 □ M 2 🔀 F Maryland May 31, 1949 show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Yes 2 No MD Baltimore 10e. Street and Number 27 Arlington Ave ò 10f. Zip Code 21229 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any niury or other traumatic event, the Medical Examiner must be a Funeral USA 21217 Pitcher Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: black. 3 Widowed 4 X Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Viola Rich Charles Smith 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latrelle Thompson/daughter 4540 Manorview Road Baltimore, MD 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation → X Other (Specify) in state Chesapeake Crematory Street Manual Cremation Services

Water Manual Cremation Services

Box 1413 Baltimore, MD 21203 5/21/2012 Beltsville, Md 21. Signature of Euneral Service Licenses Bonald S 222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ◯ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsv performed death? **Director:** After this certificate I d in by the funeral director, pag Yes 2 No 2 🗌 No I ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA MIDIAICO 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Alatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Gertifying Nurse Fractitioner To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-11-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHUMO. 21201 WILL & BOULL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 2 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of	iviai yiai		tificate of			тептат пу	Reg. No	ZUI	2	16161
	Physicia Media		1. Decedent's Name	ALB	ERT TES	STERM	AN, S	SR.			2. Date of De Month	eath Da O	y Zo	ar Z	3. Time of Death 3.55 P M
	Examir	ner	FRANK	LIN SO	give street and numbe	,	۷	4b. City, Town	or Location			4c.	County of D		RE
	Funeral Director		5. Social Security No. 219-70- Usual Residence of	-0589	6. Sex 7. 1 ★M 2 □ F	Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Day			8. Date of Bir 0 7 2 4		g.	Birthpla	ce (State or Foreign
	Maryland 28a-f show otified at	Director	10a. State MD	10b. County BALTI	MORE		ry, Town or Loc ROSED					_		100	I. Inside City Limits
	n with the lis 23a or 2	Funeral Di	10e. Street and Num 503 PA7		AVENUE			10f. Zip Code	1237			10g. Cit	izen of What	Country	/?
PETER 5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 🛣 Never Marri 3 🗌 Widowed		12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? X No	If	das Decedent of Yes, specify Cu ☐ Yes 2X N			cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify: W	hite, etc	
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了 Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or othe		20a. Method of Disp 1 X Burial 2 E 4 Donation	Cremation	3 ☐ Removal from Sta	ite c		ition (Name of atory or other pl CEMETI			ate 2/12		TIMO!		
Balt	permit. Page Department Important: any injury o		21. Signature of Fun	iera Service Li	ensee		22. 12	Name and Addi	ress of Facil	ity CVA	CH/ROS BALT	SEDA	LE FU	JNEI	RAL HOME
>	executed Medical Examiner Lial-transit	Interest of the act rained by the cause of the act line. Immediate Cause (Final disease or condition resulting in death) Best of the act rained by the cause of the act line. Best of the act line. But to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any model, to fine distance of the act line. The consequence of the act line.									proximate terval Between nset and Death Weeks				
Division of Vital Records, P.O. Box 68760		by Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ g ☐ Unknown Part II. Other signific	nonths?	d. 23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	2 Feta at time of d	death 3 aeath 5 a	Ectopic pregnar Other (specify)		L.	23e. Did to		23d. Date of o	Da	
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					o completed cause of Bar 90	death (Item	23a) (Type, Prir	nt)	0620		-o. M		2123		
	State Registra	e ³	Dr. Saya B1. Date filed (Month,	2012"	32. Reg	rar's Si	WININ	Square	VI '	DUIT	o. In	0	2100	/	

1 - For State Registrar

10a. State

heo

FRANKLIN

Usual Residence of Decedent

5. Social Security Number

229-14-4674

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

dore

10b. County

4a. Facility Name (If not institution, give street and number)

6. Sex

1 □ M 2 □ F

SQUARE MEDICAL CENTER

89

7. Age (In yrs. last birthday)

10c. City, Town or Location

2	larylar show	_	10a. State	10b. County		10c. City,	Town or						10d. Inside City Limits
)	ne Ma 8a-f	Director	MD	Baltin	nore			Ro	seda1e				1 ☐ Yes 21X No
7	ith th	ä	10e. Street and Nu		c . n1 !	1.1		10f. Zip Code			10g. C	Citizen of What Co	untry?
7	s 23a	Funeral		evonwood)	Court Bld	-		21237				ted Stat	es
	er de item	ļ.	11. Marital Status	AFT W.	12. Was Decedent 8 Armed Forces?		1	Was Decedent of If Yes, specify Cul	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Ame Black, White	rican Indian, e, etc.
-	0036 ours aft ral", or Erant	by	1 ☐ Never Marr 3 ☐ Widowed	ed 2 Married 4 Divorced	1X Yes 2 □ N If Yes, Give Year or Dates:	WWII		1 □Yes 27 No	Specify:			Specify: Wh	ite
,	Ind 21215-0036 be filed within 72 hours after death with the Marylar ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Exaction of the profiled at	Completed		15. Decedent's Edi	ucation de completed)		16a. De	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of и	rorking	16b.	Kind of Business/	Industry
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_	flaryland 2 2 should be filed w n and Mental Hygie is marked other th raumatic event, th	Be C	17. Father's Name	(First, Middle, Last)					f	ame (First, Middl	e, Maide	n Surname)	
		ပ္	Herman	n Vest					Myrt1e	Spivey			
	Maryls d 2 should th and Mer 7 is marke traumatic			me/Relationship (7)			19b. M	ailing Address (Stree	t and Number or	Rural Route Num	ber, City	or Town, State, 2	Zip Code) Mary Land
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	ges 1 ar ti of Hea if Item or othe		20a. Method of Disp 1 ☐ Burial 2	oosition ⊋Cremation 3 □ I	Removal from State			sposition (Name of crematory or other pla		Date		Location - City or	
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į	baltimor permit. Fages 1 Department of I mportant: If Ite ny Injury or of		21. Signature of Fu	neral Service Linens	see 4			22. Name and Addr Duda – Ruck					
			23a. Part 1. Enter t	ne disease, or comp	lications that caused ne cause on each lin	the death.	Do not	7922 Wise	ing, such as card	iac or respiratory	<u>viary</u> arrest,	land 21	222 Approximate
ш	Physician	n i	Immediate Cause	Final	ne cause on each lin	ie. 2		4.			VIV	+	Interval Between Onset and Death
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9	do / du, rificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):										
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0	an: The law requires that the death certificate be executed rificate has been signed by the attending physician and tor, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	in the past 12 1 □ Yes 2 □ 9 □ Unknown		4 ☐ Pregnant at 9 ☐ Unknown			3 ☐ Ectopic pregnan 5 ☐ Other (specify) _				Month	Day Year
	ires that signed to be deta	Y P	Part II. Other signif	cant conditions co	ntributing to death bu	t not resulti	ng in the	underlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
	require	ted b	#110	· CA	0					_ 10	Yes 2	2 □ No 3 □ Pr	obably 4 💢 Unknown
- 6	an: The law requir tificate has been s for, page 2 should	ple								24a. Was		24b. Were au	topsy findings available
7	The The cate h	So								perl 1 □ Yes	ormed?	death?	2 □No
	vita ician sertifi ector,	Be	25. Was case referr examiner?	ļ	In a - Mark					eath (Check only			
4	Phys ral dir	은	1 Tes 2 A 27. Manner of Death				R/Outpat Bb. Time	Herit 3 LI DOA				6 ☐ Other (Spec	cify)
Vivioion of V	Affer funer	Ę.	1 🔀 Natural	5 ☐ Pending investigation	28a. Date of Injur (Month, Day)	Year)	Injur	y Woi	ryat k? Yes 2□No	28d. Describe	how inju	ary occurred	
3	Atten deat cctor:	fica	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not be	28e. Place of Injur	ry - At home	e. farm.	street, factory, office	ites Z LINO	28f. Location	(Street a	and Number or Ru	ral Route Number.
ć	al or all	Certification: To	4 Homicide	determined	building, etc.	(Specify)	,,	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		City or To	wn, Sta	te)	rai rioate i vambei,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Medical C	29a. Certifier (Check only one)	1 ② Certifying Phy 2 ☐ Medical Exami	sician: To the best o ner: On the basis of and manner stat	examination	edge, de n and/or	eath occurred at the t	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(, date ar	s) and manner as	s stated. to the cause(s)
	To th withir To th	Me	29b. Signature and	itle of certifier	,			29c. Licens	se number		29d. D	ate signed (Month	n, Day, Year)
			Aq	colo la	1 Islan	10		D7	2785		S	18/12	2
		-	30. Name and addre	ss of person who co	ompleted cause of de	ath (Item 2:	3a) (Typ	e, Print)					
DX					ALIL	9	00	o Frank	lin SV	on De	10-11	Baltin	012
	Stat		31. Date filed (Mont		32. Registra	r's Signatur	е				1		
,	Registra		MAY 2 2 2	1012 Dens	un A.	park							
1	OHMH 17 Rev 1/20	001	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100	- 1			DICINIAL					
							O	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Months

State of Maryland / Department of Health and Mental Hygiene 2012

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

ROSEDALE

Hours

Date of Death
 Month

8. Date of Birth (Month, Day, Year)
Sept. 23,1922

03

Day

Year

BALTIMORE

2012

4c. County of Death

3. Time of Death

8.45 A~ M

9. Birthplace (State or Foreign Country) West Virginia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LAJEAN Month VERMA 2012 Physician/ 06:16 PM 05 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner University of Maryland Medical (enter Baltimore, MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 212 42 7832 **Director** 1 🗆 M 2 🕱 F 67 12/19/1944 Pennsylvania 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3717 St. Victor Street 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 Tes 2 X No Specify: Specify: ed other than "natural", event, the Medical Exa 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Balto. City Schools Substitute Teacher permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other transcript Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lamae Krause Dallas Bilheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Lacy / Daughter Baltimore, Maryland 21225 4018 - 6th Street Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Buriai 2 🕱 Cremation 3 🗆 Removal from State 05/21/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Ment 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MCA and PCA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dusito (or as a consequence on: Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the common states. IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year signed by the at the detached f P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available 24a, Was an page 2 autopsy prior to completion of cause of death?

1 Yes 2 No has ro the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in hy the first certificate Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tes 1 Nation 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year,

MD 30. Name and address of person who completed cause of death Item 23a) (Type, Print)
FILIPA A. LIGRIFO, MD University of Maryland Medical Center. Bathmore, MD

32. Registrar's Signature

1275822876

05/18/12

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 19. 2012 Benigna Α. Venturina 6:26 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Keswick Baltimore City **Funeral** 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Hours Director 217-88-2668 1 M 2 X F 94 February 13, 1918 Philippines 28a-f show 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Mary land Baltimore Nottingham 1 🗌 Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 9102 Perryvale Road 21236 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o à 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates Filipino the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juan Aleguas Toribia Guan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Connie Bacasnot (Daughter) 9102 Perryvale Road Nottingham, Maryland 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oti Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5 ☐ Other (Spec 4 Donation New Cathedral Cem. 5/26/2012 Baltimore Maryland Signatur 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition ADVANCED Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 Yes 2 No Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this ours after death.

Interpretation of the second of the sec Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Sign ture and title of certifie MD D0059056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 700 Most dow 24 Belt Ma 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2 Day Katherine Ann Webster 1:24 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Keswick Multi Care Center N/A Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 088-14-5537 **Director** 1 □ M 2X F 88 April 11,1924 New York Usual Residence of Decedent or 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland N/A Baltimore Ξ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 West 40th Street 21211 USA within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 XNo ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify. 3

▼ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Postal Worker Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev John O'Brien Jenny McNally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1315 Cuatro Cerros Trail SE Albuquerque, NM Deborah Webster, Daughter 87123 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 05/21/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Momai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death dementa, Wishermen's disease Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Month Year Pregnant at time of death detached s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 5 autopsy performe death? certificate 1 Yes 2 1 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death __ eck only one) examiner? 2 🛂 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A 1 🗌 Yes 2 Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M. Gabelle May 21,2012 13657

Registrar

State

49 th STREET

BALTIMIRE, MD 21211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

70

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wieteha 19, 7:30 A May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford 1513 Alexis Joppa Social Security Numbe Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours 1 M 2 X F 232-07-8437 **Director** 94 1918 January 3 West Virginia Usual Residence of Decedent show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Harford 1 🗌 Yes 2 💢 No Joppa 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 1513 Alexis Drive 21085 USA or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedon:
Armed Forces?

¹ ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: White "natural" 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Factory Worker Radio Equipment injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Rich Felicia DeGenova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other stands. Henry E. Wieteha son 1513 Alexis Drive, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 23 2012 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oak Lawn Cemetery Dundalk,Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ ancer disease or condition Medical resulting in death) Due to (o a a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of, if any, ledding to immediate cause. Enter Underlying Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of) Physician/Medical the t Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Month Day Year ed by the g 🗌 Unknown P.O. signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ arteru Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? certificate OSTEOPOROSIS 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 100 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death To the Funeral Director, A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотрыете (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

FRANKLIM SOUNDE PZ-205

BALTIMORE MD.

ompleted cause of death (Item 23a) (Type, Print)

9101

Division of Vital Records, P.O. Box 68760, or Attending death. To the Hospital 24 hours

DHMH 17 Rev 1/2001 11595

State

Registrar

(check only

29b. Signature and title of certifier

DANIEL

31. Date filed (Month, Day, Year)

MAY 2 2 2012

Kim

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 20; 2012

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ 18, 10:17 A M Anna Veronica Webber May Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Boonsboro 6025 Moser Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 🗆 M 2 🔀 F 146-16-7372 Usual Residence of Deceder Director New Jersey July 21,1922 89 28a-f shov 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland notified at Director 1 Yes 2 No Penobscot Hancock MF: 10f. Zip Code 10g. Citizen of What Country? o 10e Street and Number pe ed other than "natural", or items 23a event, the Medical Examiner must be Funeral **USA** 237 Dunbar Road 04476 Page 1 and 2 should be filed within 72 hours after death vert of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Yes 2X No 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugenia Della Paolera ပ္ Samuel Beaumont 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6025 Moser Road Boonsboro, MD 21713 Gail Webber / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of 1
Important: If its
any injury or of □ Burial 2 X Cremation 3 □ Removal from State Final Journey Crematory 5/21/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Meral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ vears Chronic Lymphocytic Leukemia disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ası IF FEMALE asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performe Yes 2 X N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? daughter's Other: 4 Nursing Home 5 Residence Other (Specify 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work?
1 Yes 2 No eral Director; A Investigation
6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) ure and title of certifier May 18, 2012 D23623 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1110 Medical Campus Road Suite 130 Hagerstown, MD 21742 Frederic H. Kass 32. Registrar Signat 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:30 AM Helen Woerner MA> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medical Center Washington ANNIE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 217-40-5946 1 M 2 X F 68 07/09/1943 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes XX No Glen Burnie Anne Arundel 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 7975 Apt. 407 21061 Crain Hwy, S U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Duffy Levander Kimes, Sr. Dorothy Virginia Carter 19a. Informant's Name/Relationship (Type, Print) 21061 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7975 Crain Hwy, S Mr. Ronald D. Woerner / husband Apt. 407 Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 \square Burial 2 $\overline{\mathbf{X}}$ Cremation 3 \square Removal from State Atlantic Crematory 5/22/2012 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD MU1357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If ves. outcome of pregnancy

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After this certificate has

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Director:

or Attending Physician:

To the Hospital within 24 hours a To the Funeral I

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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IF FEMALE:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician	in the past 12 months? 1 Yes 2 No 9 Unknown	1	23d. Date of delivery Month Day Year
by	Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐
Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
70	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Residence 6 Other (Specify)
ertificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) Injury work? 1	28d. Describe how injury occurred
O	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, an iner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practitioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Howard Sawyer Williams, M.D. 20, 2012 May 12:40 P.^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Hours Director 522-86-1001 1**X** M 2 □ F 54 Baltimore, MD. Oct. 18, 1957 filed within 72 hours are tall Hygiana.
set other than "netural", or items 23e or 28a-f show
set other, the Medical Examination retified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Baltimore County Baltimore 1 🗌 Yes 2 🏿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Wellington Road 21212-1921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married ል Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 08 Internist Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mortimer Lee Williams, M.D. Shirley Sawyer 1 and 2 should by Haaith and Meitem 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Leonard Williams (Wife) 906 Wellington Road Baltimore, Maryland 21212-1921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town State (Harford County) parmit. Pege 1 Dapertment of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State Tuesday Evans Fureral Charel and 4 Donation 5 Other (Specify) May 22,2012 Cremation Services, Inc. Forest Hill, Maryland Part Service Lights and Cremetric Center, P.A.

2. Name and Address of Facility Service Funeral and Cremetric Center, P.A.

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4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Dav 1 Yes 2 No ed by tha e or Attending Physician: The law requires that the o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 25. Was case referred to medical of Vital funarai diractor, Be 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence (1) Other (Specify) Work of Ce ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th compietely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4
Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my original documents. 29a. Certifier 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) 058303 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C701 N. Cerantes AMON W) UNNUES ST (IN NOCHUT 32. Regist ar's Sign sture

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Edward Leo Willis May 16, 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Parkville Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 220-24-6315 **Director** 1 XM 2 □ F 82 July 24,1929 Maryland 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd Apt. 1103 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) CSX Yard Master 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည William E. Willis Alice Virginia Leadley or other traumatic f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15812 Ensor Mill Road-Sparks, Maryland 21152 Joan Bourne-cousin-in law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel
and Cremation Belair 1 Burial 2 Cremation 3 Removal from State May 18,2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 LMS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Fine disease or condition Limonua Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a nonsequence of: If any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown ate has been signed by the atte page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, SAIDH 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an was an autopsy performed? this certificate has 1 Yes 2 500 1 Yes 2 To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. RO6734 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 2 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Chia-Ling Wu 2012 11:12 Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 👿 F Months October 14 China Country) 554-64-7173 91 Yrs. Director Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6719 Surreywood Lane 20817 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify item 27 is marked other than "natural", other traumatic event, the Medical Exar Completed 3 X Widowed 4 ☐ Divorced Specify: Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Main Ting Shen Ju Ren Cheng 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Sally Wu /Daughter 6719 Surreywood Lane, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 18. ð Department of Important; If it any injury or o 1 Burial 2 X Cremation 3 Removal from State May 4 Donation 5 Other (Specify) 2012 Bethesda, Maryland 21. Signature of Funer, Service L. See

When the Durant Robert A. Fumphrey Tuneral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as circliac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Months. Sequentially list conditions, cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Vear Pregnant at time of death the Unknowr Unknown in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ - nal 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy perform 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this n 24 hours after death.

The Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Charles W. Karesh,

MD

32. Regist

9701 Veirs Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 16, 2012 **Physician** William Yienger 5:48а м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Overlea Health and Rehab Baltimore City n/a 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 😾 M 2 🗆 F 212-36-9480 Mary I and Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Modical Examinar must be notified at Director Marvland | n/a 1 √Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1821 Edison Highway 21213 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify. ģ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Glenmore Service Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other than Station Gas Station Attendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aurther B. Yienger Marie Hittel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Protoni/Guardian B606 Bayonne Avenue Baltimore.Marvland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/17/2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rebroversculen Sequentially list conditions, if any, leading to ininediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 🔀 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) firsana m. Osler 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Sever S. parked

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $20\overset{\text{Year}}{1}\overset{\text{Year}}{2}$ Frank Zavilinsky, Jr. May 7:25 PMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chevy Chase 8411 Lynwood Place Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F October 25, 1944 Pennsylvania Director 163-36-8467 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 🕅 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a8411 Lynwood Place 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or Completed by 1 X Never Married 2 Married and 2 should be filed within 72 hours after or Health and Mental Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examir 1 ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company 4 Computer Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Frank Zavilinsky Mary Kendra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8411 Lynwood Place, Chevy Chase, Maryland 20815 Vicky Zavilinsky /Sister other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. lette Brin Chaga M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Intel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dementid disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence oi). burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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State Registrar NAV 9 2 2012

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Page 1 and nent of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	other place)	te 20c.	Location - City or Town, State
Department of Important: If any injury or once.			nd Address of Facility	10 Frapial	TON JOST BUTTIND
7 C = 6 0		23a. Right 1. Inter the disease, or complications that caused the death. Do not enter the moshocia or heart failure. List only one cause on each line.	de of dying, such as cardiac or	respiratory arrest,	Approximate
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uted d ansit	Examiner	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury that initiated events C.			
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To the His Lord of Attending Physician: The law requires that the death certificate by within 24 hours after 1948. within 24 hours after 1948. within 14 hours after 1949. within 14 hours after 1949. completed filled in by the funeral director, page 2 should be detached for use as the to the page 1949.	Medical (29a. Certifier 1 **Decertifying Physician: To the best of my knowledge, death occured a Check 2 **Medical Examiner: On the basis of examination and/or investigation, in	my opinion, death occurred at the	ne time, date and pla	ce, and due to the cause(s) and manner state
To the within 2 To the comple		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occ		and due to the cause	
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State of Maryland 7 Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month ATKINS TEVEN RAY MAY 1151 AM LDIL Medical **Examiner** 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Columbia buntu towan 1 Year If Under 24 Hrs. If Under Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Min (Month, Day, Year) 219-94-6652 Director 1 M 2 □ F 34 Yrs 22, 1978 Jan. Maryland show the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified a 28a-f MD 1 XX es 2 No Howard Columbia ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 11389 Little Patuxent Pkwy., #915 21044 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XXo
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 XX Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 XXio Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Grade 12 Service Manager Property Management event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
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r other traumatic ever Page 1 and 2 should be Steven R. Atkins Amanda Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Rebecca Joy Atkins / spouse 11389 Little Patuxent Pkwy. #915 Columbia, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 🛣 remation 3 ☐ Removal from State W. Arundel Crematory! 4 Donation 5 Other (Specify) 5/25/2012 Odenton, Maryland 21. Signature of Funeral Service Liminsee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, GR /M00770 Maryland 20707 23a. Part 1. Enter the disease, or pmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List or one cause on each line Immediate Cause (Final Onset and Death Ph sician/ PULMONAKY EMBOLUJ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CANLER GASTRIL Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsv certificate Yes 2 No 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending death. Investigation 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple 29d. Date signed (Month, Day, Year) 0053051 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane. Columbia, MD, 21042 Walter Atha 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #28d, per me, g928 6-8-12 sm. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 554A M 2010 Medical Facility Name (if not institution, give street and number) 4c. County of Death or Location of Death Examiner Mole Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Min. (Month, Day, Year) Director 213-06-7022 1 🔀 M 2 🗆 F 40 1972 Jan. 26, Maryland 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director of Health and Mental Hygiene.
ilem 27 is marked other than "natural", or items 23a or 28a-f sl
other traumatic event, the Medical Examiner must be notified i 1 X Yes 2 □ No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US<u>A</u> 305 Sandy Spring Road 20707 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Painter Self Employed 11th а Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည pe Robert Lee Amigh Emilie Bastine Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Stephanie Hughes/Wife 305 Sandy Spring Road, Laurel, MD <u> 20707</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) MD National Mem. Pk 5/22/2012 Laurel, MD 22. Name and Address of Facility Signature of Funeral Service License Donaldson Funeral Home, ▶ M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Inter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proxi erval shoc Immediate dause (Final O set n Death Ph sician/ 00 disease or condition resulting in death) Medical Due to (or as a con a quence of: Examiner CERTIFICATION APPROVED BY MED Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami use as the burial-transi or Attending Physician; The law requires that the death certificate be executed after death. and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months Day Month Year 2 LINO been signed by the s should be detached 1 ☐ Yes ∠ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv perform death? 2 No this certificate Oca Yes 2 No 1 Yes IN Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗌 No 2 1 Depatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred subject took drugs Certificate: 24 hours after death. Funeral Director; After 1 Natural
2 Accident (Month, Day 5 Pending unknown 1 Yes 2 No 2012 Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Laurel 305 Sandy Spring home 010 Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causes) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UV NP ene rca do 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Abe 30 PMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fahrney 8507 Madeville Rd Buchsburg Washing ton Countr If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 W Hours 215-22-1882 04/27/1928 **Director** MD Usual Residence of Decedent 28a-f show 10b. County 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 1 Tes 2 No WASHINGTON HAGERSTOWN 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a 1427 KENSINGTON DRIVE, #102 21742 USA er than "natura, , ... the Medical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ HYMAN ENGERLIEB IDA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 27 DEBORAH A. CRESS/DAUGHTER 12805 THE TERRACE, HAGERSTOWN, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP 4 Donation 5 Other (Specify) 05/20/2012 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Michael 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on V ause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovas cula disease or condition lo weeks Medical resulting in death) Due to (or as a consequence of) **Examiner** ~ 5 weeks Pheumonia Sequentially list conditions, if any sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events soulding in doubt least Examine Divide for each densirolaring of Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No funeral director, page 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After the Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination arrow investigation, in my opinion, social section and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie D0071052 MD 6/19/2012 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 7 Blud Smithsburg State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 5:34AM Becks Helen Marv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Regional Hospital Laure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/27/1933 Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 🗷 F Hours 78 225-32-9199 Virginia Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at with the Maryland Director 1 X Yes 2 No Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 20001 500 N Street NW permit, Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 amy injury or other traumatic event, the Medical Examiner mus once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes: 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Black Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ρ Helen Brown John Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 125, Esmont, VA 22937 Lucian B. Jackson, Sr Brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Teague Cremation Service Burial 2 Cremation 3 Removal from State 5-12-2012 Charlottesville, VA 4 Donation \$ Other (Specify) Metropolitan Funeral Service 21. Signature of Fureral Service License 22. Name and Address of Facility 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Yedrs Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 anding purse as t 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death signed by the a 9 Unknown 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? Seizures 24a. Was an autopsy has performed? Yes 2 No Respiratory Failure 1 🗆 Yes 2 🗆 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No Natural Accident injury 5 Pending thin 24 hours after death the Funeral Director: A mpleted filled in by the fu Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifie 2012 D28998

Registrar

DHMH 17 Rev 7/2009

State

9101 Cherry Lane, Suite 211

Laurel, MD 20708

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Saini

2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	larylanc		rtment of H tificate of D		Mental Hy	_	2013	16187
			Registrar 1. Decedent's Name (F	First, Middle, Last	t)		Cer	incate of L	,catri	2. Date of De		2010	3. Time of Death
	Physicia		DONNA	BICHOP						Month	Day 13	2012	1329 PM
	Medic Examin		4a. Facility Name (if no		street and number)			4b. City, Town, or	Location of Death		4c.	County of Deat	1
			UNIVERSITY		LYLAND ME				ALTIMORE				
	Funeral Director		5. Social Security Num 212-48-21		7. Ag	ge (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Cou	hplace (State or Foreign intry)
-			Usual Residence of D		101 2 23 1	64	Yrs.			06/01/	1947	Mar	yland
	f sho	호	10a. State	0b. County		1	Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🛂 No
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	vith th		1330 Cypre					21851				5.A.	ondy.
	tems	Funeral	11. Marital Status	100 1000	12. Was Decedent			/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp			14. Race - Ame	
36	ifter d ", or i amin	2	1 Never Married		Armed Forces? 1 ☐ Yes 2 2 If Yes, Give		- 1	Yes 2 No		nican, etc./		Black, White Specify: T.T	
21215-0036	ours a atural	Completed	3 Widowed 4	X Divorced 15. Decedent's Ed	Year or Dates.		16a Deced	ent's Usual Occupa	ation			nd of Business/	hite
7	n 72 h an "n Medi	dm	(Specify	y only highest gra		5+)	(Give k	ind of work done a NOT use retired)	luning most of work	ding .			•
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and	e filec ntal H ed ot	To Be	17. Father's Name (First	st, Middle, Last)	Unknown				18. Mother's Nam	ne (First, Middle	Maiden S	Surname)	Olikhowh
Maryland	ould b id Mei mark matic		19a. Informant's Name	e/Relationship (Tv	ne. Print)		19h Mailin	g Address (Street a	and Number or Rui	al Route Numb	er City or	Town, State, Zir	Code)
	12 shealth an 27 is r trau	Ì	James Bis		, , ,			Cypress					, 2000,
ore,	of Hear		20a. Method of Dispos	sition	Removal from State		ace of Dispos	sition (Name of natory or other place		Date		cation - City or	Town, State
<u>m</u>	Page ment tant: I			Other (Specify		- I	any Gif	ts Registr	y 05/2	2/2012_		over, M	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rigury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funer	al Service	BE A	5 1		Name and Addres				s Regis	try MD 21076
			23a. Part 1. Enter the	disease, or comp	olications that cause	ed the death.							Approximate
all the	Ph_ici_n/		Immediate Cause (Fin disease or condition		ne cause on each lir	ne.							Interval Between Onset and Death
	Medical Examiner		resulting in death)	•	a. Due to (or as	•							
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,60	cate be executed physician and s the burial-transit	edical Examiner		•	d								
687	ertifica ding p se as 1		IF FEMALE:		23c. If ves. outcome	e of pregnan	CV					23d. Date of de	livon
Box 687	requires that the death certific. been signed by the attending p should be detached for use as	Completed by Physician/M	23b. Was decedent proint the past 12 mg 1 Yes 2 1	paths?	4 Pregnant	at time of de		Ectopic pregnand Other (specify)	У		1	Month Month	Day Year
В	the de by the tacher	hys	g 🗌 Unknown		g 🗌 Unknown								
P.O.	s that gned be de	by F	Part II. Other significa										the cause of death?
rds	equire	eted	MORBID OF	-		-			7	24a. Was			topsy findings available
000	e law i e has b ge 2 s	ldm	PULMONAR	Y HYPER	TENSION,	ATRI	AL FIR	LATION_		auto	opsy ormed?	prior to death?	completion of cause of
E E	an: Th tificate tor, pa	Be Co	25. Was case referred	to medical				26. Pl	ace of Death (Chec		2 No	1 L Yes	2 12 No
Zit:	nysicia nis cer I direc	To B	examiner?	No	Hospital: 1 🛂 Inpa	tient 2 🗆 E			er: 4 Nursing H	ome 5 Res	idence 6	Other (Spec	ify)
) of	ing PI		27. Manner of Death 1 Natural	5 Pending	28a. Date of inj (Month, D		28b. Time of injury	work	?	28d. Describe	how injury	occurred	
sior	death ctor: / y the	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not be		iury - At hon	ne, farm, stre	M 1 L	Yes 2 ☐ No	28f. Location	Street and	d Number or Ru	ral Route Number,
Division of Vital Records,	al or A s after il Dire		4 Homicide	determined	building, e	tc. (Specify)		,		City or To	wn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2	Medical Exami	sician: To the best oner: On the basis of	examination	and/or invest	igation, in my opinio	on, death occurred	at the time, date	and place,	and due to the	cause(s) and manner stated.
	ithin 2 o the P	Me	only one) 3 29b. Signature and titl	Certifying Nurs	se Practitioner: To t	he best of m	y knowledge,	death occurred at t	he time, date and p	lace, and due to	the cause	(s) and manner a	is stated.
	F ≥ F ŏ		▶ P.	The 1	2 Crip				33788			19 20	
	•		30. Name and address	s of person who c		death (Item :	23a) (Type, P		>>/4{		· 107/	1,50	
				EMBA		ENE	STREE	T BALT	IMORE, MI	ARYLAN	D 0	2/20/	
	Sta Registr		31. Date filed (Month,	Day, Year)	32. Regist	trar's Signatu	ire						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ronald Edward Bunting 2012 12:35AM Medical May 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Director 213-34-8240 1 1 M 2 □ F 76 03/05/1936 Maryland Usual Residence of Deced item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4004 Kahlston Road 21236 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7, Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Quality Engineer Aviation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Bunting Gough L. Ruth Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine E. Bunting / Spouse 4004 Kahlston Rd., Perry Hall, MD 21236 Baltimore, 1 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of himportant: If ite any injury or other Date 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 105/18/2012 4 M Donation 5 ☐ Other (Specify) Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CANCER disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events Due to (or as a consequence of) y physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 M Other (Specify) Hospite ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of collifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimose 6701 N Charles Street Suite 4105 ABBAS 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month REPKERIDGE JAMES 5 2012 05 15:20 PM M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kingsville Baltimore 7631 Donny Terrace Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Yea 1**X** M 2 □ F Director 214-20-9782 02 10 Maryland ER KERIDG Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD Baltimore Kingsville 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral U.S.A. 21087 7631 Donny Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Ever III of S. Armed Forces?

1 X Yes 2 No
If Yes, Give Korean
Year or Dates Conflict the Medical Examiner Black, White, etc. ō δ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify White "natural" Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Crown, Cork & Seal Co. 8 <u>Foreman</u> Be altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o မ Frank J. Berkeridge Fronie Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trat. (wife) 7631 Donny Terrace - Kingsville, Maryland 21087 Maeve Berkeridge 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem U.M. Ch. Cemetery 05/21/12 Upper Falls, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. J. 9 11750 Belair Road - Kingsville, Maryland 21087 assa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 5 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 23e. Did tobacco use contribute to the cause of death? ð 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? vascular . 24a. Was an autopsy Rheumatoi 1 ☐ Yes 2 ☐ No **Division of Vital** the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{A}\) Residence 6 \(\sum \) Other (Specify) Hospital: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Investigation 2 Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calculated and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration and Tellis configuration and the cause within 2 3 ... Certifying Nurse Practitioner To the best of my knowledge, deeth conu 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9524 KMSTINE SAL Below Rd Raltmore MD 21231 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 19^{ay} 2012^{al} MAY BOYD WILLIE C. 2:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S **CHEVERLY** PRINCE GEORGE'S HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 73 **Director** 578-52-2870 1 🗶 M 2 🗆 F Yrs JAN 3 1939 SOUTH CAROLINA Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits at 10a, State 10b. County within 72 hours after death with the Maryland Director notified 28a-f 1X Yes 2 □ No PRINCE GEORGE'S BOWIE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ritems 23a or ner must be n Funeral USA DRIVE 20720 12705 QUARTERHORSE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1965 Specify "natural", 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT EEO INVESTIGATOR permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ AILEEN DALTON JOHNNIE BOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12705 QUARTERHORSE DRIVE BOWIE, MARYLAND 20720 JEANETTE BOYD/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BRENTWOOD, MARYLAND FT. LÍNCOLN CEMETÉRY 5/25/2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death.

I Director: After the 28c. Injury at Natural 5 Pending work? 2 🗌 No Accident
Suicide Investigation 6 Could not be filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and til 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a, b per fh g927 5-23-12 vt

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month 05 Year **Physician** eNE 4:15 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTEMORE Balto 00 Person Parkway Conten If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Days Vear) Months 248-52-058 1**X**M 2□ F 03-28-1936 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Exp. Inc. I uset by notified at 1XYes 2 □ No BALTIMORE Director MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21239 STONEWOOD ROad Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No Saltimore, Maryland 21215-0036 Specify. Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry YELLOW CAB Elementary/Secondary (0-12) College (1-4or 5+) AB DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BLAKELY EBECCA ပ 19b. Mailin 109 re6 60 dean Stembe Loaf yr Eng NurSer, Cit 29 360 State, Zip Code) TONEWOOD Rd. BALTO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation CROWNSville, MD 3 Removal from State 5/23/12 Rownsville 4 Donation 5 Dother (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNCKAR SCKS 21. Signature & Funeral Se YORK ROAD. BANTO, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death > 10 years Immediate Cause (Final DEMENTIF **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): Box 68760. physician certificate be Physician/Medical use as the attending properties as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy The law requires that the death in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 Other (specify) P.O. | the detached 9 Unknown 9 Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No certificate has page 2 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Iniur_\ 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R15217 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANAPOISM Marshacee Dr. Elkredge, MD21075 6095 31. Date filed (Month, Day Year) State

DHMH 17 Rev 1/2001

Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death edent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Eacility Name (if not institution, give street and number) **Examiner** 4b. City. Town Passon If Under 7. Age (In yrs. last birthday) 1 Year If Unde Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 6-1942 Year) Months Days MD Director 214-40-7019 1 XM 2 □ F 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MDn/a 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21215 USA 3737 Manchester Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc , or þ 1 Never Married 2 X Married 1 Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene, item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 10th Supervisor Recreation and Parks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Virginia Anderson James Edward Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Bernett/Wife <u>3737 Manchester Avenue, Baltimore,</u> MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o of Burial 2 Cremation 3 Removal from State 5-26-2012 Druid Ridge Cemetery Pikesville, MD Donation 5 D Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 . Signaturé of funerat 9ervice Licensee le 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause nterval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death be detached g 🔲 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy After this certificate Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred I or Attending F ofter death. 1 Natural 5 Pending injury within 24 hours after decth. To the Funeral Director Al 1 Tes 2 🗆 No 2 Accident
3 Suicide Investigation th 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Number Transfill Court To the Least Tray in could be a court of at the time date and place, and other transfer as dates. 29a. Certifier (Check 2012 Name and address of person who completed cause of death (item 23a) (Type, Print) 90 61 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ LORRAINE BRANNAN May 20 2012 10:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard 5412 Harris Farm Lane Clarksville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** NOV. 5 Days Hours Min. ^{Yea}1936 578-48-0016 75 Washington, DC Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at rector 28a-f MD Howard Clarksville 1 Ves 2 XXVI ۵ 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 21029 U.S.A. 5412 Harris Farm Lane items ? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 XXNo Black, White, etc. 1 Never Married 2 XMarried permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ Maryland 21215-0036 1 Yes 2XXNo Specify If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12)
Grade 12 College (1-4 or 5+) Secretary Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Ellis Eileen Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Brannan, Jr spouse 5412 Harris Farm Lane Clarksville, Maryland 21029 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 5/25/2012 Brentwood, MD 21. Signature of Functal Service Licenses 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a, Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. shock, or heart failure. List Interval Between Immediate Cause (Final Onset and Death **Physician** Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami certificate be executed nding physician and use as the burial-trans Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter Hospital or Attending Physician: The law requires that the death of thours after death.

24 hours after death.

Funeral Director, After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Pregnant at time of death Month Day Year 5 Other (specify) been signed by the a should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, 1 Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 **XX** 1 Tes Division of Vital 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 XXesidence 6 Other (Specify) 2 XX0 ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XXatural 5 Pending Investigation 1 Yes 2 No Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Si ure and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi rar's Si

Dr. Martin Weltz

D23743

M.D. 7525 Greenway Center Drive Greenbelt, Maryland

May 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 9:35 P M 18, Martha J. Bowler May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Silver Spring 3148 Gracefield Rd. #125 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 05/07/1922 \mathbf{P}^{untry} **Director** ٩n 181**-**18-2802 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Oc. City, Town or Location
Silver Spring Director MD Prince Georges 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20904 USA 3148 Gracefield Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?.

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Philanthropy traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 7. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Martha Wilson မ Daniel Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 Chilham Rd. Balto, MD 21209 Linda B. Pierson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 25, 1 Burial 2 K Cremation 3 Removal from State Chesapeake Crem. Inc. 4 Donation 5 Other (Specify) 2012 Beltsville, MD 22. Name and Address of Facili Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licenses Kebocca 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or ilinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed?
Yes 2 N prior to completion of cause of death?

1 Yes 2 No has After this certificate **Division of Vital** • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nusse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

10g

DHMH 17 Rev 7/2009

State

Registrar

Machado 3110 Gralffield Dr. Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 2 3 2012

D24035

05/21/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth BRANCH Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Randallstown Season Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-74-4190 Min 1**¥**1 M 2 □ F Months Days Hours 5 14 / 5 9 ear) Director MD Yrs. 28a-f show 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 Yes X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 2024 McElderry St. USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Univ. of MD Hos 12 Environmental Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eddie McCulloh Pauline Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Forrest/Aunt 4105 Eastmont Ave, Balt., MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 5/25/12 Balt., MD Carmel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune at Sanice License 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ma Medical e to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): y physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No detached for 5 Other (specify) Month Pregnant at time of death Day Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 10 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After completely filled in by the funer Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

29a Certifier (Check

only one

Date filed (Month, Day, Year)

3 2012

DHMH 17 Rev 06-2011

State

Registrar

6936

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per 1h g928 6-18-12 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Month **Physician** 5:01 PM Louie August Baerwolf MAY 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stagnes

5. Social Security Number HOS pita roun 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min 1**)** M 2 □ F Days Hours 391-22-3215 91 Director March 14,1921 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director E1kridge Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21075 6620 Washington Blvd. Lot 74 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, It. Medical Examples in the Institute of the context. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Army Depot Security Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Mante Hugo Baerwolf ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 Grant Road, Halethorpe, Maryland 21227 THeresa C. Mercer - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 05/19/2012 Charleston, SC Carolina Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Gary L. Kaufman F.H. @ MMP 22. Name and Address of Facility 21. Signature of Funeral Service License 7250 Washington Blvd., Elkridge, Maryland M01283 Approximate Interval Between Onset and Death 23a. Part . En er the diseas or complication, that caused the shock, or heart failure. List only one cause on each line or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** one day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ACUTE RENAL PAILURE, CHRONIC KIDNEY OKEASE-1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown STAGE 4, CORONARY ARTERY DISEASE, DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ 100 24a. Was an autopsy performed? 1 Yes 2 No ESSENTIAL HYPERTENSION certificate Vital Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Matural Injury 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signaturn and title of certifier 29c. License number Kanal 5-15-2012 D0018362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Komal K. Dang MD., 3455, Wilkens Ave, Ste LIO, Baltimore, Md21229 10 V 3455, Wilkens 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

AERWOLF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03783 State of Maryland / Department of Health and Mental Hygiene Dominique Barnes Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 18, 2012 0024 hrs M cal Examiner Dominique Μ. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Country) MD July 12,1991 Director 20 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State 1 Yes 2 No or 28a-f show MD Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 USA 3447 Juneway 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes SpecifyBlack 1 Yes 2 X No specify: If Yes, Give Year 3 Widowed 4 Divorced the Medical Examiner Š 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 none none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leslie Brooks Harvey Barnes Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Leslie Brooks (mother Balto Md 20c. Location - City or Town, State 20a, Method of Disposition 1 K Burial 2 Cremation 3 Removal from State = 5 King Mem. Pk. May 24,2012 Balto, Md permit. Page:
Department o
Important:
injury or oth 4 Donation 5 Other Specify 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MC Approximate Interval Between Onset and Physician /Medical Multiple Gunshot Wounds Immediate Cause (Final disease xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P. 0. 1 Yes 2 No 3 Probably 4 Unknown 5 Completed 24b. Were autopsy findings available 24a. Was an Records, has been s prior to completion of cause of death? autopsy performed? 1 🗸 Yes 2 No ✓ Yes 2 No certificate page 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 this 1 🗸 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury 27 Manner of Death After Subject was shot May 17, 2012 2345 hrs 1 Yes 2 V No 1 Natural Division Pending Director: death. Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. To the Hospital or Att within 24 hours after do To the Funeral Direct filled in by Could not be 3 Suicide or Town, State) 2600 Block of Mathews Street, Baltimore, MD determined (Specify) Local Street 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Windical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 18, 2012 O.C.M.E

DHMH 17 Rev 1/2001

State Registrar

32. Registrar Signatu

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

20. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1fem 6 per fh 927 5-23-12 vt State of Maryland Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2 Maxwel 1235 BM Darbour 10 Max Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomera VOSS urtonsvil 1-101 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral -**M 2 **□** F 267-84-705 102 Yrs Months Days Hours Min. (Month, Day, Country) **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at 10a. State Director 1 Yes 2 No aure ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Montpelier 20708 within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1. Marital Status 14. Race - American Indian, Examiner Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: Specify: 3 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ennie permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informan 's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montpelier DarDow 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 1 Burial 2 Cremation 2012 4 Donation 5 Other (Specify) 21. Signature of Fareral Service Licer 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Me Physician/ tustati Ovarian disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any hearing to immediate cause. Enter Underlying Examiner Due to or as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day ρ Year ed by the a detached f g Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ effusions Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed npleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Preumonia 24a Was an has performed' hin 24 hours after death.

the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred Certificate: Matural 5 Pending 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chee only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number ₹ 6 D0053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oreencust 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT MATTHIAS COULBOURN May III 2012 3:00 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1055 West Joppa Road, #225 Towson Baltimore County 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min. 219-20-5096 Director 1 💢 M 2 🗆 F 87 Feb 15, 1925 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director notified 1 ☐ Yes 2X No Maryland Baltimore County Towson 10f. Zip Code ò 10e. Street and Numbe 10g. Citizen of What Country? must be Funeral items 23a 1055 West Joppa Road, #225 21204 12. Was Decedent Ever in U.S. Armed Forces?

1 by Yes 2 □ No 1 43-146
If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò b 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Wire Manufacturing <u>Engineer</u> Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Matthias Coulbourn, Jr. Margaret Anderson Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Adams Coulbourn (Wife) 1055 West Joppa Road, #225, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 5/24/2012 Baltimore, Maryland 21, Signaturyo, Furtiral Serve Local see MITCHELL-WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryl Martin D. Lawson Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between a. Walden Onset and Death Immediate Cause (Final Macros/250line trom's Physician/ disease or condition resulting in death) / Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed fibrilla hon 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 NO Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Division of Vital Records, 24 hours a

> State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's MAY 2 3 2012

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗌

Timothy Souweine

29b. Signature and title of certif

21 West Road

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

#100

29d. Date signed (Month, Day, Year)

MD 21204

Towson,

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last. 2. Date of Death Physician/ Jar 01 5:00AM 20 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 mor 8. Date of Birth Month Day Year Nov 15 1945 9. Birthplace (State or Foreign **Funeral** M 2 □ F 218 44 1185 66 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 Yes 2 □ No Maryland 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 23a or 21225 Funeral with 1312 Pontiac Avenue items 2 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian. Armed Forces?

1 x Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ō þ 1 X Yes Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify than "natural", Year or Dates. army 3 Widowed 4 X Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygiene.

27 is marked other that traumatic event, the N Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental 1 Important: If item 27 is marked o any injuy or other traumatic eve once. ပ Geraldine Ferguson Jack Cole 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1312 **Pontiac Avenue Baltimore, M**D 21225 girlfriend Joyce Purper 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State May 24, 2012 Baltimore, Maryland Bavview Crematory 4 Donation 5 Other (Specify) 21. Signature of Funded anvice 22. Name and Address of Facility McCully Polyniak Funeral Home, P.A. 237 East Patapsco Avenue Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) (and Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying and -transit The law requires that the death certificate be executed that initiated events resulting in death) Last physician are the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Pregnant at time of death Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No has 2 🗌 No 1 Yes fo the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 욘 1 Impatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one MO Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ une Ma 012 Medical Examiner bor imere If Under 24 Hrs 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) **Funeral** Hours Director 91 212-34-1649 1 🗆 M 2 🗶 F June 26, 1920 Virginia or 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 21230 U.S.A. 1104 Riverside Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Effie Dean Rossum Harlow traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5508 Park Road Brooklyn Park, Maryland 21225 Health a Sharon Garcia daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cedar Hill Cemetery 1 M Burial 2 Cremation 3 Removal from State May 22, 2012 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facili Acculty Polyniak Funeral Home, P.A. Signature of Euneral Service Licensee 1270 237 East Patapsco Avenue, Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
3 PG / 5 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3) (Type, Print)
505 E. Ritchie Highway
Browlelyn, Md State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me,g927,05/22/2012dhb
Certificate of Death
Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 28ª LEON CALDWELL RAYMOND 1120 AM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Health System **Allegany** Cumberland If Under 1 Year If Under 24 Hrs. 6, Sex 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Hours 73 232-60-8164 Director 1**X** M 2 □ F oct.20,1938 WV 10c. City, Town or Location 28a-f shov at 10a. State 10b. County 10d. Inside City Limits Director items 23a or 28a-f s per must be notified 1 Yes 2 X No WV Hampshire Augusta 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 26704 USA HC-71 Box 147C 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 5 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: "natural", Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) WV Dept. of Hwys. Foreman 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dakota Kidwell Willis Caldwell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a
Important: If item 27 is
any injury or or Augusta, WV 26704 HC-71 Box 147F (daughter) Lisa Short 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 5/2/12 Augusta, W 4 Donation 5 Other (Specify) Tearcoat Cemetery 21. Signator of Funeral Service Lice 22. Name and Address of Facility mcKee Funeral Home Inc. Augusta. WV 26704 Box 270 P.O. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death neumonia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Po Month Year Day Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 6 24a. Was an autopsy has page 2 performed? certificate 2 1 To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer MU D 68539 2012

State

Registrar

30. Name and address of pe

31. Date filed (Month, Day, Year)

MAY 22

625 Kent

Arc#304, Cymberland MD 21502

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	•				and M	lental Hy	_	012	16201
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate	OI L	<i>Jeain</i>		2. Date of De		012	
	Physicia Medic		NANCY EILEEN COAKLEY						Month May		1012	3. Time of Death 6:36 P M
-	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, To	own, or	Location	of Death			y of Death	
-,}			228 Marganza S.			urel			Anne Arund			de1
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last)	<i>birthday)</i> Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th 9 , Year 1958		place (State or Foreign
			216-74-9778 54 Usual Residence of Decedent						Plat CII	J	,,,,,	- V11911114
	land f shov	tor	10a. State 10b. County 10c. City, To	own or Loc	ation						1	0d. Inside City Limits
	Many 28a-	Jirec	MD Anne Arundel Laur	cel		_						1 Yes 2XXNo
	ith the	ral	10e. Street and Number		10f. Zip (ode 0724				10g. Citizen of U.S.A		try?
	ems 2	Funeral Director	228 Marganza S. 11. Marital Status 12. Was Decedent Ever in U.S.	13. W	Vas Decede	nt of His	spanic Or	igin? (Spec	cify Yes or No-		ce - Americ	an Indian.
õ	fter de , or it amine	ρ	1 Never Married 2 X Married 1 Yes 2 1 No		Yes, specif				Rican, etc.)	Bla	ick, White, e	etc.
3	tural	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.								w. Whi	
င်	n "na Medio	Completed	(Specify only highest grade completed)	(Give k	ent's Usual aind of work O NOT use r	done di		st of workir	ng	16b. Kind of E	Business Inc	dustry
77.7	withir giene er tha		Elementary/Seconday (0-12) College (1-4 or 5+) Grade 12	Payr	oll Ad	dmin	nistr	ator		Payro	11	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland antial by/giene. Wed other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)						(First, Middle, Carpent	Maiden Surnan	ne)	
Z Z	should be file h and Mental I 7 is marked o rraumatic eve		Rondle Ables 19a, Informant's Name/Relationship (Type, Print)								0 7. 6	
Σ	12 shouth and the and		Anthony Coakley / spouse		g Address (i Marqai				<i>Route Numbe</i> ≥1, Mar	r, City or Town, yland	State, Zip C 20724	;ode)
ře,	ge 1 and 2 should be tt of Health and Men t If item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place		sition (Name		ol.	D	ate	20c. Location	- City or To	wn, State
Ē	Page ment ant: It ury or		I L Dunai 22020/emation 5 L Hemovarion State		1 Cre			5/26	5/2012	Odento	n, Ma	ryland
Baltimore,	permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee / M0 0 7 **	70 22.	Name and Donald		i official	eral	Home,	P.A. el, Mar	vland	20707
		Н	23a. Part 1. Enter the disease, or complications that caused the death. D								1	Approximate
4	nysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic	Brea	st Ca	ncer	2					Interval Between Onset and Death Years
	Medical Examiner		resulting in death) Due to (or as a consequence)									
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	ce of):							_	
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X	exection and and and and and and and and and an	dical Examiner	that initiated events c. Due to (or as a consequence presulting in death) Last	ce of):								
20	ate be ohysici the bu		d								\rightarrow	
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X P O	eath c atten d for u	Physician/Me	in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal de 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat		Ectopic pro Other (spe		у					Day Year
	t the d by the tacher	Phys	9 Unknown 9 Unknown									
<u>. </u>	Attending Physician: The law requires that the death certificate be executed er death. er death. er death. by the funeral director, page 2 should be detached for use as the burial-transit.	by	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying ca	iuse givi	en in Part	l.				e cause of death?
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Kecords,	e law e has l	Completed							auto perfo	osy	prior to cor death?	mpletion of cause of
<u>~</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical			26. Pla	ace of Dea	ath (Check		2 & No	1 🗌 Yes	2 🔼 No
VIta	nysici nis cer I direc	To B	examiner? 1 ☐ Yes 2√√√√ No	/Outpatien	t 3 🗆 DQA	Othe	r: 4 🗆 N	ursing Hor	me 5 🔀 Resid	dence 6 🗆 Ott	ner (Specify))
101	ling Pl		1 X Natural 5 ☐ Pending (Month, Day, Year)	b. Time of injury	- 1	c. Injury work?	?	_	8d. Describe h	now injury occur	red	
JIVISION	Attendii death. ctor: Ai y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	, farm, stre	et, factory,		Yes 2		28f. Location (S	Etreet and Numl	er or Rural	Route Number.
<u> </u>	The Hospital or Attending Physician: The law requires that the death certificate be executed the Hospital or Attending physician and the Funeral Director dath. The Funeral Director dath. The Funeral Director at the funeral director, page 2 should be detached for use as the burial-transit and the funeral director.		4 Homicide determined building, etc. (Specify)	, ,					City or Tou			
1	2 Accident 3 Accident 3 Suicide 4 Homicide 4 Homicide 5 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 7 Suicide 8 Suicide 8 Suicide 8 Suicide 8 Suicide 9 Suic										use(s) and manner stated.	
7	Vithing Vithing Comp.	Σ	only one) 3 U Certifying Nurse Practioner: To the best of my kn 29b. Signature and title of certifier	очнецуе, а			number	o and place	, and due to th	29d. Date signe		
5	_		Rente Mo			D43	346			May 2	21, 20	12
	9		30. Name and addless of person who completed cause of death (Item 23 Dr. Gupta 8926 Woodyard Road,	#201	Clin	ton	, Mai	rylan	d 2073	35		
	Stat		31. Date filed (Month, Day, Year) NAY 2 3 2012 32. Registrar's Signature	bar	1		,	1				-
	Registra	ar	MAY 23 2012 CENTER 1.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16205 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Dav Daniels Cole Gladys 2012 9:30a Medical 05 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Future Care Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) Days Hours Director 219-10-2146 1 □ M 2 🛣 F 25 86 11 06 MD ral", or items 23a or 28a-f show Examiner must be notifled at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore NA MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21216 3610 Windsor Mill Road U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. .00 Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give "natural", 3X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Public School Cafeteria Aide 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Priscilla Satchel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Graywing Ct., Columbia, Md 21045 Dana Cole-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 5/29/2012 Crownsville, 22. Name and Address of Facility March F/H West 4300 Wabash Av 21. Signature of F 21215 Ave Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner a Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 2-110 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate ha performed? 1 Yes **Division of Vital** 25. Was case referred to medica funeral director Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 🗌 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner eath hours after death. neral Director: After th y filled in by the funera Certificate: 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Matural 5 Pending 2 Accident 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0200 ted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ Month Dichele A. Claggett 627 1M May 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1002 Mcaleer Court Baltimore N/A Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours 213-86-6959 1 🗆 M 2 🔀 F 8/20/69 42 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director N/A Baltimore 1 🖾 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? 1002 Mcaleer Court 21202 USA ural", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ★ Never Married 2 ☐ Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 🗆 Widowed 4 🗆 Divorced Amer Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College Elementary/Seconday (0-12) College (1-4 or 5+) Student 12 Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanfield Brogdon ဂ္ Debroah A. Claggett ^{19a.} Informant's Name/Relationship (*Type, Print)* Durrell Chikoade Igwe/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3714 Fleetwood Ave, Balt., MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5/24/12 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun al Service Licensee 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Ental the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ perposino disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to jor as a consequence of cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 horurs after death.

To the Funeural Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 X Yes 2 No ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Lack Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar hael Fi-

Date filed (Month, Day, Year MAY 9, 3 2011)

Registrar's Signature

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N I			Registrar 1. Decedent's Name (First,	Middle, Last)		Ce	runcai	e or L	<i>Deatri</i>		2. Date of De	Reg. N	lo.	114	2 Tim	e of Death
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3	Examin		4a. Facility Name (if not ins	titution, give s	street and number)			4b. City,	Town, or	Location (of Death			c. County			
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2	Funeral Director		217 - 92 - 458		x □ M 2 【 X F	ige (In yrs. la	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year,		9. Birthp Count	lace (Sta ry)	te or Foreign
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Janc	be file ental I ked o ic eve	10 E	Larry Wats									e (First, Middle Ford		n Sumam	<i>e</i>)		
Son Maryland	hould and Mi s mar umati		19a. Informant's Name/Re		pe, Print)		19b. Mail	ng Addres	(Street a	and Numbe	er or Rura	l Route Numb	er, City	or Town, S	State, Zip C	ode)	
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$lpha \; \omega / lpha t$ Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	100.0	20a. Method of Disposition 1 ☐ Burial 2 🎇 Crer		Removal from Sta		lace of Disp emetery, cre	osition (Nai matory or o	ne of ther plac	e)	[Date	20c.	Location -	- City or To	wn, State	•
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Mera ■ Ba			23a. Part 1. En me dise shock, of leart failure	ase, or comp	lications that caus	ed the death								<u> </u>	110	Approxi	mate
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No.	Medical Examiner		resulting in death)	C	Due to (or a						,					<i>'</i> 2 s	· et a
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Box 68760	certific nding (use as		IF FEMALE: 23b. Was decedent pregna	ınt 2	23c. If yes, outcom	ne of pregna	ncy							23d Da	ate of delive	erv.	
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<u> </u>	ian: T ertifica ctor, p	BeC	25. Was case referred to mexaminer?						26. Pl	ace of Dea	ath (Check	1 □ Yes k only one)	2,0	Noj	I ∐ Yes	2 LJ NIO	
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Division of Vital Records, P.O.	ding F	Certificate:	27. Manner of Death 1 ☑Natural 5 ☐ 2 ☐ Accident	Pending	28a. Date of in (Month, L		28b. Time of injury	t i	8c. Injury! work!		- 1	28d. Describe	how inj	ury occurr	red		
isio	Atten er dear ector: by the	řţį	3 Suicide 6 🗆	Investigation Could not be determined	28e. Place of I					103 2 [-	28f. Location			er or Rural	Route N	umber,
Οį	ital or urs afte al Diru		, a riomola	dotominod	building,	etc. (Specify	")					City or To	wn, Sta	te)			
	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. Othe Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 🗌 Me	dical Examir	ician: To the best ner: On the basis o	f examination	n and/or inve	stigation, in	my opinio	on, death o	ccurred at	the time, date	and pla	ce, and du	e to the cau	se(s) and	manner stated.
	To the within To the compl	Σ	only one) 3 - Ce 29b. Signature and title of	_	e Practitioner: To	the best of n	ny knowledg		urred at t		ate and pla	ace, and due to			manner as s ed (Month, L)
			> Then	RL	, be	in he	ers 6	21	D:	325	80			5	120	/20	5/2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:02 arr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Care Center If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months 1 M 2 T Days Min. Hours (Month, Day, Year) 6/4/1927 84 Pennsylvania **Director** 196-22-9405 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director 1 ☐ Yes XX No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21227 3015 Michigan Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Pharma Plastics 8 Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Edna Pear1 Kough Cessna Frank Roy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3015 Michigan Ave., Baltimore, MD 21227 Wanda Messerschmidt (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/22/12 Pikesville, Maryland 4 Donation 5 D Other (Specify Entombment Druid Ridge Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physiciani 122 Medical resulting in death) Due to (or as a consequence of) Examiner 0/0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine as a consequence of, Due to (or To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transi Due to (or as a consequence of). attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Por 5 Other (specify) Month Day Year the detached P.O. | ģ Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner P Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	tate of Maryland				d Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of E	<i>Jeatn</i>	2. Date of De	Reg. No.	012	1620
	Physicia		Arthur Daniel Co	ordoll Ir				Month	Day	2017	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street			4b. City, Town, or	Location of De	eath		nty of Death	,
مميون			ST. AGNES HOSP	ITAL_		BALTIMO	ZE M	D			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 I		th v. Xeerih	9. Birth Cour	place (State or Foreign
	Director		219-52-5201 1 LSM Usual Residence of Decedent	² 63	Yrs.			03-07-	1949		Maryland
	and show lat	or	10a. State 10b. County	10c. City	Town or Lo	cation				1	10d. Inside City Limits
	Maryla 18a-f	Director	MD				Bal:	timore			1 K Yes 2 No
	a or 2	Ö	10e. Street and Number	-		10f. Zip Code			10g. Citizen o		-
	h with	Funeral	770 W. Cross Street				1230		Unite	d Sta	tes
	r dear		A	Vas Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		ace - Amerio lack, White,	
930	s afte ral", c Exam	d by	XX	Yes 2 X No f Yes, Give 'ear or Dates.	1	Yes 2 X No	Specify:		Spec	ify: W	hite
2	hour hatul	Completed	15. Decedent's Education (Specify only highest grade con	on	16a. Deced	lent's Usual Occupa kind of work done d	ation	westing	16b. Kind of		
2	nin 72 ne. Ihan ' e Me	om		College (1-4 or 5+)		O NOT use retired)		working	Monu	factu	rina
5	filed within 72 hours after death with the Maryland al Hyglene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			Laborer		A (F*		ıfactu	I Tild
anc	be file ental H ked o c eve	To E	Arthur D. Cordell,	Sr.		Ì		Name <i>(First, Middle,</i> Dorothy G		me)	
ar _Z	should be file and Mental I is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Pr		19b. Mailir	no Address (Street a		Rural Route Numbe		. State. Zip (Code)
Š	d 2 shalth a alth a 127 is		Dawn Klosterman - co	ompanion	1	-		, Haletho			
ore,	of He		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Remo			sition (Name of natory or other place	e)	Date	20c. Locatio	n - City or To	own, State
Ĕ	Page ment o tant: If ury or		4 Donation 5 Other (Specify)		lowrid	ge Mem. P	ark 05	-22-2012			aryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Gervice Libense	volacus)) 22 MI	. Name and Addres	s of Facility (Gary L. Ka ash. Blvd	aufman ., Elkr	Funer	al Home at MD 21075
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau		. Do not ente	er the mode of dying	g, such as card	liac or respiratory ar	rest,		Approximate Interval Between
~~ <u>.</u>	Ph, sici_n	5	Immediate Cause (Final disease or condition		ASP IR	ATORY F	HLUR	E			Onset and Death
	Medical Examiner		resulting in death)	Due (or as a conseque							
		er	Sequentially list conditions, b. —	Chechonola	man all					- 1	X48
	ed	Examiner	cause. Enter Underlying Cause (Disease or iinjury	50 -211 11 2 1	1	1. 10 5 E					nowths
	be executed sician and burial-transit	Еха	that initiated events c. — resulting in death) Last	Due to (or as a conseque	ence of):	AP Co.					
09	cate be executed physician and the burial-transi	dical	d								
9/89	certificat nding ph use as th	Mec	IF FEMALE:								
		Physician/Me	23b. Was decedent pregnant 23c. If	yes, outcome of pregnan	death 3	Ectopic pregnanc	у			Date of deliv Month	ery Day Year
Box	e dea the a	ysic		☐ Pregnant at time of de☐ Unknown	eath 5∟	Other (specify)				VIOTILIT	Day Tour
д. О	that the death ned by the atte detached for		Part II. Other significant conditions contribu	iting to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to t	he cause of death?
	uires 1 n sign ild be	ed by	PULMENARY EMBO	45m				_ 1 🗆	Yes 2 □ No	3 🗆 Pro	babiy 4 🗆 Unknown
000	law requires nas been sigr e 2 should be	plete	ATRIAL FIBRIL	1.4.T10N				24a. Was			psy findings available
ě	sician: The law r certificate has b lirector, page 2 sl	Completed		-21				— autor perfo	rmed?	death?	empletion of cause of
ē	sian; 1 ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (C	Check only one)	2 110		
5	hysic this ce al dire	မ	1 ☐ Yes 2 ☑ No	1 Inpatient 2 - E			4 ☐ Nursin	g Home 5 Resid	dence 6 🗆 O	ther (Specify	/)
<u></u>	ding F	ate:	1 ☑ Natural 5 ☐ Pending	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occu	urred	
Division of Vital Records,	Attend death ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Be. Place of Injury - At hon	ne farm stre		Yes 2 □ No	28f Location (9	Street and Nun	her or Rura	l Route Number,
\leq	al or A s after I Dire d in b		4 Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,		City or Tow		iber er riara	Troate Nambel,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician:	To the best of my knowle	dge, death o	occured at the time,	date and plac	e, and due to the ca	use(s) and mar	nner as state	ed.
	the H hin 24 the Fi	Med		ctioner: To the best of my							
	5 wit		29b. Signature and little of certifier	14-10		29c, License	number		29d. Date sign	ned (Month,	Day, Year)
			Male Jale	IV, MY.	20-1 7	120	7.56		MIT	[/]	S 612
-	SV		30. Name and address of person who comple	eted cause of death (Item 2 900 Source 32. Register's Sitter	zsa) (Type, P	mil)	- Rus	TIMERE I	10 2	2291	
	Stat	е	31. Date filed (Month Day) 2 2012 Level	32. Registrar's Si	de	100 AV6.	, , , , ,	11			
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Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 05 Physician/ JOHN CALLAWAY 5:22 PM 012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UMM C-UNIVERSITY OF MARYUM) MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 260-66-1156 **Director** 1 X M 2 🗆 F 03-17-1944 Massachusetts show 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 🕱 No MD Anne Arundel Hanover 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral 21076 United States 1905 Pometacom Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 K Yes 2 No 1965 Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: 1985 Specify: White Completed 3 Divorced Year or Dates of Health and Mental Hygiene.

item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Elementary/Secondary (0-12) College (1-4 or 5+) Security Agency Physicist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Virginia F. Tompkins John C. Callaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Pometacom Drive, Hanover, Maryland 21076 Jean Redifer - spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 05-24-2012 | Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at f Funeral Service L MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ACUTE STROKE disease or condition Medical resulting in death) Due to (or as a consequence of) 2.HRS Examiner ATTUAL FIBRILL ATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine YEARS CCIONARY FRUTTY
Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be a
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia
reley filled in by the funeral director, page 2 should be detached for use as the burn
as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ☐ Live Birth 2 ☐ Fetal deat ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ADVANCED HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29d. Date signed (Month, Day, Year) 1376870964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHAIMORE, MD 21201 S. GREENE STREET PAUNIONC Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 9 per fh g927 5-24-12 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20,2012 Phyllis Collins May 8 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Aug. 20, 1928 Months Min. Hours Country) unk. 213-26-4652 Director 83 1 M 2 ST Yrs Usual Residence of Deceder 1 end 2 should be filed within 72 hours after death with the Maryland if Heelth end Mentel Hygiene.
Item 27 is merked other then "neturei", or Iteme 23e or 28e-f show other treumetic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 N. Washington St. Apt.303 21231 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X <u>\$</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specif\Black 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only high est grade completed) Baltimore /city Elementary/Secondary (0-12) College (1-4 or 5+) School Attendant Dept. Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Earl Crook Thelma Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code21231Douglas Collins (husband 201 N. Washington St. Apt. 303 Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1
Department of
Importent: If It
eny Injury or o Pege 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest May 30,2012OwingsMills,MD 21. Signature of Funeral Service License 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 Ε. Preston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Debilin Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami been signed by the ettending physicien end should be detached for use es the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FFMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Physicien: The lew requires that the death Month Day Vear 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á luding Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? discesse 24a. Was an hes page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Bether (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hoepitel or Attendir within 24 hours after death. To the Funerel Director: Af completely filled in by the fu death. Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 20202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Clinass Tonson MA CHANES NV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 3 2012 Registrar

DHMH 17 Rev 06-2011

State

Registrar

30. Name and adj

JACKIĖ JONES,

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

so of person who completed cause of death (Item 23a) (Type, Print)

CRNP

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 1 per pHYS, G928, 6727, 2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) **Lorie** 2. Date of Death 3. Time of Death Physician/ Month Davis 2012 15 12:20 8m May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9322 Ridings Way Prince George's Laurel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 228-32-2971 Director 1 □ M 2 🔀 F 82 Yrs. Nov 25, 1929 Virginia Usual Residence of Decedent or 28a-f show notified at show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code ms 23a or must be r 0 10g. Citizen of What Country? Funeral 9322 Ridings Way 20723 USA er than "natural", or items the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: **Black** If Yes, Give Year or Dates Specify: 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)
Commercial Laundry Machine Operator Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the N Commercial Laundry 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Mason Bertha Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Murray Davis - Son 9322 Ridings Way, Laurel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Sullivan County Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-25-2012 Liberty, NY 21. Signatura Funeral Service Exenses 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, Virginia 22310 23a Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cardiac, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Chrone Widney disease disease or condition Medical resulting in death) Due to (or as a consequence of up mentit **Examiner** Cachezia sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): areunysma delatation the burial-transi Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical partension Division of Vital Records, P.O. Box 68760 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atter in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hepothy reiden 2 No 3 Probably 4 Unknown Completed X Yes plnods been 8 arenva of 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate be completely filled in by the funeral director, pag 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 24 hours after death. filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Gu cius + မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No NIA Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 29a. Certifier 🍱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)37035 2012 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21208 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar		epartment of Health and Ce <i>rtificate of Death</i>	, ,	ene g. No. 2012	16211
	Physicia		Decedent's Name (First, Middle, Last) Mylyawr	DIXON		2. Date of Death Month	Day & Year	3. Time of Death
A.,	Medic Examir		4a. Facility Name (if not institution, give st		4b. City, Town, or Location of Des		4c. County of Death	1
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hr Months Days Hours Mir	s. 8. Date of Birth	Howa 9. Birthp	place (State or Foreign
	Director		220-30-47/3 1 L Usual Residence of Decedent	M 2 DF 93 Y	rs. Months Days Hours Min	Month, Day, Y.	(Coun	(ry) MD
	aryland a-f sho ified at	ector	10a. State 10b. County	and 10c. City, Town of El	or Location /// CO-H C/H		1	0d. Inside City Limits 1 1 ★ 2 □ No
	th the Manager 198	al Dir	10e. Street and Number	Bidos Ol	10f. Zip Code	10	g. Citizen of What Coun	
	feath wil	Funeral Director	3701 Bonny 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ	an Indian,
036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ρ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puè 1 ☐ Yes 2 ☐ No Specify:	rto Hican, etc.)	Black, White, e	etc.
15-0	72 hour n "natu Aedical	Completed	15. Decedent's Edu (Specify only highest grad	lication 16a. E le completed) ((Decedent's Usual Occupation Give kind of work done during most of wife. 10 NOT use retired)	orking 16	6b. Kind of Business Inc	dustry
1212	ed within 'Hygiene. other thar ent, the M	Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5+)	Custodian		exal Go	verweat
/lanc	ld be filed Mental Hy arked oth atic event	To B	17. Father's Name (First, Middle, Last) LOUIS DIXO	X	18. Mother's N	ame (First, Middle, Ma.	den Surname)	
Baltimore, Maryland 21215-0036	2 shou th and 7 is m traum		19a. Informant's Name/Relationship (Type	e, Print) 19b. I	Mailing Address (Street and Number or F	Pural Route Number, Co	ity or Town, State, Zip C	Code)
ore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition 1 Deurial 2 Cremation 3 R	20b. Place of D	Disposition (Name of crematory or other place)	Date 20	Oc. Location - City or To	wn, State
altim	mit. Pag bartmen bortant: r injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	2 / Bushy	1 fork 5/ 22. Name and Address of Facility 1	26/2012	COKSVIlle	*
Ä	permi Depar Impor any in		Melia C	I forwel It.	10220 Guilfe	- [, Jessur	ND
	Physician/	-	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the death. Do not a cause on each line.		c or respiratory arrest,	· .	Approximate Interval Between Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a consequence of)) (1)10			90
	,	Examiner	Sequentially list conditions, but all any cause. Enter Underlying	Due to (or as a consequence of)				
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260	icate be executed physician and s the burial-transit	edical	d					
P.O. Box 68760	eath certifica attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy		23d. Date of delive	,
. Bo	the dear	hysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 U Other (specify)		Month	Day Year
s, P.(• Hospital or Attending Physician: The law requires that the death certific 24 hours after death. • Funeral Director: After this certificate has been signed by the attending eted filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions conf		the underlying cause given in Part I.		cco use contribute to th	
cord	aw requ as been 2 shoul	Completed	100			24a. Was an autopsy	24b. Were autop	psy findings available impletion of cause of
Division of Vital Records,	sician: The law certificate has tirector, page 2 s		25. Was case referred to medical		26. Place of Death (Chi	performe 1 Yes 2	d? death?	
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ivision	or Atte after de Directo in by th	Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital or, within 24 hours afte To the Funeral Dire completed filled in t	Medical	(Check 2 Medical Examine	On the bacic of examination and/or is	ath occured at the time, date and place, overstigation, in my opinion, death occurred	lot the times date and a	بيمت مناه مه مديات امينم مممار	Latata Lauranau (a)
	To the within 2 To the comple	_ ,	only one) 3 Certifying Nurse	Practioner: To the best of my knowled	ge, death occurred at the time, date and p 29c. License number	lace, and due to the ca	use(s) and manner as sta	ated. Pay, Year)
			> Sles jen	~60	D 34868	5	121/2012	
	5		30. Name and address offerson who con	npieted cause of death (Item 23a) (Typ. 3- 1055 L I	ge, death occurred at the time, date and p 29c. License number 34868 De, Print) The Shryest (7c #103	Colubra a	w 2/344
	Stat Registra	·	31. Date filed (Month, Bay, Year) MAY 9.3 20	32. Figurar's Signature	have			

DHMH 17 Rev 7/2009

	1-	For State Registrar			- Iviai	ylallu /		tificate			and iv	ена пу	Reg. N	0.0	012	16	21
Physician	/ _N	Decedent's Name Iya Ahmad		ast)								2. Date of De Month		ay L 6	2012	3. Time of 2:17	
Medica Examine		Facility Name (if n		ve street and nu	ımber)					Location	of Death			c. County	of Death		
Funeral		13209 Gre Social Security Nur		rive Sex	7. Age (li	n yrs. last b	irthday)	Ro _If Under	ckvi 1 Year	11e If Under	24 Hrs.	8. Date of Bir	th	Mont	gome1	lace (State o	or Foreign
Director		386-10-76		1 □ M 2 💢F			Yrs.	Months 3	Days 1	Hours	Min.	(Month, Da	y, Year)		Count		or r or orgry
and show		Isual Residence of a. State	Decedent 10b. County		1	Oc. City, To	wn or Loc	ation		L					11	0d. Inside C	ity Limits
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r items		Marital Status		12. Was Dec	cedent Eve orces?	r in U.S.	13. W	/as Deced Yes, spec	lent of His	spanic Ori n, Mexicar	igin? (Spec	cify Yes or No- Rican, etc.)			e - America k, White, e		
ours after	-	1X Never Marrier 3 ☐ Widowed 4		1 ☐ Yes If Yes, G Year or I	iive)	1	☐ Yes	2 🛚 No	Specify				Specify:		nite	
72 hou 72 hou ledical	Completed	(Speci	15. Decedent's fy only highest (d)	16	(Give k	ent's Usua ind of wor	k done d		t of workir	ng .	16b.	Kind of Bu	usiness/Inc	lustry	
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and 2 s Health em 27 ther tra	-	Feras Hal		ather						Dr.		kville					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	208	1 X Burial 2 4 Donation 5	Cremation 3			20b. Place cemet	ery, crem	atory or o	ther place		_	ate -2012			City or To	wn, State cy1and	l
permit. Page 1 Department of Important: If is any injury or once.	21.	Signature of Fune		**	n Deil		22.	Name an	d Addres	s of Facili	ty D	anzans	ky-(Goldb	erg		
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- Physician/		shock, or heart i imediate Cause (Fil sease or condition	,			ory Fa	ailur	e e							. 3	Interval Bet Onset and I Days	ween
Medical Examiner		sulting in death)		Due to	o (or as a co	onsequence	of):										
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ding Pt After th funeral			5 Pending	(Mo	e of injury nth, Day, Ye		Time of injury		Bc. Injury work?	?		8d. Describe h	ow inju	ry occurre	ed		
or Attending Fafter death. Director: After I in by the funer		2 Accident 3 Suicide 4 Homicide	Investigation Could not determined	be 28e. Plac	e of Injury -	- At home, f	arm, stree	M et, factory,		Yes 2		8f. Location (S			r or Rural I	Route Numb	oer,
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To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director. After this completely filled in by the funeral death. Medical Certificate: To	298	(Check 2 L	Certifying Ph Medical Exan Certifying Nu	niner: On the ba	asis of exam	nination and/	or investig	gation, in n	ny opinior	n, death oc	curred at t	he time, date a	nd plac	e, and due	to the caus	se(s) and ma	nner stated.
To t with To t	29b	. Signature and titl	e of certifier	<	1	1/		29c.	License	number	0 3	,	29d. Da	ate signed	(Month, D	ay, Year)	
	30.	Name and address	of person who	completed cau	MV use of death	h (Item 23a)	(Type, Pr	M(54.5	518		- 6	116	11 -		
]	Melissa.]	. Schwa	artz, M	D - 1	8111	Prin	ce Ph		Dr.	, #31	l1, 01n	ey,	Mary	land	20832	2
State Registrar	31.	Date filed (Month	AY 232	012	negistrar's	Signature	40	ترمص	,								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Joseph Loman Fiagoy 6

•		1- For State Registrar		-	ificate of		id Meritar	, ,	Reg. No	. 201	2 62
Physici Medical Exam		1. Decedent's Name (First, Middle,						2. Date of De	ath		3. Time of Death
Medical Exam	IIICI	Joseph L. Fiago: 4a. Facility Name (if not institution,				City Town	or Location of De	Month May 16, :		4c. County of Dear	1810 hrs
		Shady Grove Hospital				Rockville	. 200410110120	, , , ,	- 1	Montgomery	
Funeral Director		151-92-1963	Sex 7. Age (I	n yrs. las	et birthday) Yrs.	If Under 1 Ye Months Da		B. Date of B		M/DD/YYYY) 9. Bi Fore C	irthplace (State or ign Philipines ountry)
*uy		Usual Residence of Decedent 10a. State 10b. County	10	c. City, T	own or Location	1					10d. Inside City Limits
ne Maryland nr 28a-f show any fied at once.	5	MD Montgo	merv	Mo	ntgomer	y Villa	age				1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number				10f. Zip Code	0		10g. Ci	itizen of What Cou	intry?
th the 23a nr notifie	ral Di	10652 Wayridge				20886			_	Jnited St	tates
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a nr 28a-f show rother traumatic event, the Medical Examiner must be notified at once.	Funera	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divor	12. Was Decedent Ev Armed Forces? 1 Yes 2 X and If Yes, Give Year		If Yes		ın, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0-	White, etc.	rican Indian, Black,
urs aft Itural'	d by	15. Decedent's Education (Specifi	or Dates:	ted) 1			ation (Give kind o	of work done	16b.	Specify: Kind of Business	Asian
6 172 ho cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			_	e. DO NOT use i	retired)			•
withir giene.	a mo	17. Father's Name (First, Middle, La	2		Maint	enance				Health (Care
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Andres Resurrec	,					me (First, Middle, Loman	Maider	i Surname)	
21, rould b d Men is mar	To	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing A	ddress (Stre			mber, C	City or Town, State	e, Zip Code)
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Impartant: If item 27 is m injury ar other traumatic.		Juliet Fiagoy - 20a Method of Disposition	Wife	001 51	10652	Wayric	lge Dr.,	Montgom	nery	Village	e, MD 20886
Baltimore, vermit. Pages I ar Department of Hecimpartant: If ite		1 Burial 2 Cremation	3 Removal from State	cre	ace of Disposition	place)		Date		Location - City or	
Itimen: Page of the contract o		4 Donation 5 Other Spec		Nat	ional (ne and Addres	-	22-12			ch,Virginia
Ba Perm Depz Imp			Edward Sage	1						Goldberg	: 1and 20852
Physician		23a. Part I. Enter the disease, or co failure. List only one cause on	mplications that caused the	death. D	o not enter the	mode of dying	, such as cardia	or respiratory an	rest, sh	ock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Athe		otic Cardiov	ascular Di	sease				Death
6		Sequentially list conditions,	Due to (or as a conseque b.	ence of):							
	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
=	хаш	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):	_	_			_		-
and - trans			d								
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED					· ·	-		
5876 rrificat rnig ph		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	f pregnar	2 Fetal	death 3	Ectopic preg	nancy	23	d. Date of delivery Month	y Day Year
Box 687 he death certific the attending for the as the	Physician/	1 Yes 2 No 9 Unknow	4 Pregnant at time 9 Unknown	of death	5 Other	(Specify)					
D. B tr the d by the		Part II. Other significant condition		not resu	Iting in the und	erlying cause (given in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
ires that the signed by the detached	d b							1 Yes	s 2 🗸	No 3 Prob	pably 4 Unknown
ords w requi	Completed							24a. Was autop			topsy findings available completion of cause of
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Division of Vital Records, rate death. The law require rs after death. In Directur: After this certificate has been sited in by the funeral director, page 2 should be	유	1 ✓ Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury		VOutpatient 3 Bb. Time of Injur		Other Nurs	sing Home 5 28d. Describe I		ence 6 Other	
ion C tending eath. In: Aff	Certification:	1 Natural 5 Pending	(Month, Day, Year)		oo. Timo or injur	·	ry at vvoik?	200. Describe	now inju	ary occurred	
ViSi or Att frer de Nirectr in by t	ifica	2 Accident Investiga 3 Suicide 6 Could no	20a Dinas of Injury	- At home	e, farm, street, f	actory, office b	uilding, etc.			ind Number or Ru	ral Route Number, City
Divi	Sel	4 Homicide determin						or Town, S	itate)		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the complete of the contract of th	edica	one) 2 Medical Examin	cian: To the best of my kno er:On the basis of examina and manner stated.	wledge, tion and/	death occurred or investigation	at the time, da	ate and place, ar , death occurred	nd due to the caus	e(s) an and pla	d manner as state	ed. e cause(s)
	≊	29b. Signature and title of certifier	0/11/	30	Se .	29c. Licens			l	Date signed (Mon	nth, Day, Year)
	-	30. Name and address of person who	completed assessed	(Itar 22		0.C.I	VI.⊏.		Мау	/ 17, 2012 	
			Scompleted cause of death Assistant Medical Ex			altimore S	treet, Baltim	ore, MD 2122	23		
	_	31. Date filed (Month, Day, Yeâr)	32. Republic s Si	gnature	1 2	1.1					
Regist	ćI _	MAY 23	2012 June	1	1. pa						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 21 Pay 2012 LOIS FEITH 9:00P ANITA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. Hours **Director** 139-38-4379 64 1 □ M 2**X X**F 04/21/1948 New Jersey 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medicel Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1XX Yes 2 ☐ No Maryland Baltimore None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 5812 Kipling Court USA 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2VX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes XX No Specify: specifyWhite 3 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Social Worker Non Profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sol Charles Feith Hilda Poser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5812 Kipling Court Baltimore, Maryland 21212 David Shegan Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of h Important: If ite any injury or ot 1 XX Surial 2 Cremation 3 Removal from State Druid Ridge Cemetery 05/29/2012 |Pikesville, Maryland Donation 5 Other (Specify) gnature of Funeral Say ic/Lic 22. Name and Address of Fact Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Varian disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 1 Yes 2 VNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 뾻 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 A Other (Specify, 1 ☐ Yes 2 KNo မ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this of filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 X Natural injury 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signaty 29c. License number D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suile 4105 Baltimore MD 21204. N Charles ABBAS SYED 6701 Sheel 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#20perpHYS, G927, 5/2372012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Elsie Fisher May 0048 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Overlea **Baltimore** Franklin Square Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** 1 🗆 M 2 ី F Months Hours Min Director 213-22-9488 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 USA 3406 W. North Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes ※☐ No Specify. Specify: African-American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 In and Mental Hygiene.

7 Is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Security Private Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke. any injury or other traumatic e Raymond Wilson Lillie Mae Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 W. North Avenue, Baltimore, MD 21216 Tawanna Fisher/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Mem. Park 5-19-2012 Arbutus, MD 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acupe Immediate Cause (Final Physician. disease or condition MY Medical resulting in death) Due to (or as a consequence of) Examiner 010W114 Sequentially list conditions Examiner Due to for as a consequence of) any, leading to immediate cause. Enter Underlying burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events J EN CHOU and resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 phys the L as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ò in the past 12 months? Month Day Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 🛱 No 1 Yes မြ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death. filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопретер (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERD A 200 wordington 41230 20 M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Fowler. Carroll F. May 012 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GenesisElderCare- Heritage Ctr Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🔀 M 2 🗆 F Months Hours Min (Month, Day, Yea Director 212-84-4235 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Md. Baltimore Dunda1k 1 Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1919 Maxwell Avenue U.S.A items 2 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. "natural", 3 Divorced 4 Divorced Specify: White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 12th permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ti once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Carrol1 F. Fowler, Jr. Mary Campoli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Maxwell Avenue Baltimore, Md. Dany Guadagna -Caretaker 21222 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mav 4 ☐ Donation 5 ☐ Other (Specify) 0ak Lawn Cemeterv 22, 2012Baltimore, Maryland Signature of Funeral Solvice Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA M00933 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

15 Hoursal Director: After this certificate has been signed by the attending physician and eled filled in by the furnerial director, page 2 should be detached for use as the burlansit ansit. that initiated events resulting in death) Last Due to (or as a consequence of); Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 TOR 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Pheck only one) Hospital: MNo Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature à of certifie ath (Iten 23a) (Type, Print) 410-MOR

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16220 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Venus Rochelle Green 2350 05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Agnes Hospita Balbmon 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours 247-26-8770 90 1921 S. Carolina Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21216 1519 Poplar Grove Street USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Balto. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me City Public Schools College (1-4 or 5+) Elementary/Seconday (0-12) Educator 5+years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Palmer Kizzie Beauford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Green/Son 5022 Pembridge Ave.Baltimore, Maryland 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Md.National Cemetery 6/1/12 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Sign wre of Funeral Service Licenses 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore, MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pulseless Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pulmonary Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Difficile Colitis attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day ☐ Pregnant at time of death ☐ Unknown signed by the a d be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Polycythemia Hospital or Attending Physician: The law requires 24 hours after death.
 Funeral Director: After this certificate has been sign 2 Mo 3 ☐ Probably 4 ☐ Unknown Green, Youns 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Hypertension 25. Was case referred to medical examiner? Yes completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) 2 👿 No Other: 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building_etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P23624 8 30. Name and add who completed cause of death (Item 23a) (Type, Print) 900 S. Coton Ave. Baltimore, MD. 21229

State

Registrar

31. Date filed (M

alle

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 2012 Gilbert May 3:20 Sue 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Apr. 26 Days Min Months Hours 75 937 West 10b. County 10c. City. Town or Location Mercer Princeton 10f. Zip Code 10g. Citizen of What Country? 24739 U.S.A.

1. Decedent's Name (First, Middle, Last) Physician/ Virgie AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Adventist Hospital Social Security Number 9. Birthplace (State or Foreign Country) Jest Virginia **Funeral Director** 235-60-3926 Usual Residence of Decedent show 10a. State be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No WV 10e. Street and Numbe Funeral 153 Peppermint Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗓 No Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Health Care traumatic event. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental H P Homer Allen Dunn permit. Page 1 and 2 should be Department of Health and Ment Important: if item 27 is marke any injury or other traumatic e once. Janice McLaughin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Gilbert 232 Fern Street, Princeton, WV Son 24740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Rose Lawn Memorial Gardens Bunal 2 Cremation 3 Removal from State 4 ☐ Sonation 5 ☐ Other (Specify) 05-17-2012 Princeton, WV 21. Sign ture of Fur eral Service Lic ፙዸ፞፞፞፞፞ጕኇ፞፞፞፞፝፝፝፝፞፝፝ቔቔ፟ጜ፞ጜጜኯ፟ጜጜኯ 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Severe Sepsis disease or condition Medical resulting in death) Examiner Chronic Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events Anoxic Encephalopathy attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş End Stage Renal Disease Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been Dialysis Dependent . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Director: After this certificate I 2 X No 1 Tes 2 No Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 Tyes 2 X No Inpatient 2 ER/Outpatient 3 DOA Other: မြ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 \square Pending work? 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State within 24 hours a

To the Funeral C Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 220 made D 68005 MAY 11th 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Ste. 5100, Takoma Park, MD 20912 Jennifer Enuka Obiadi, MD

State Registrar

31. Date filed (Month, Day, Year)

MAY 23

32 Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 5 Physician/ harles L . Grossman 5:55AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Revitz House ocial Security Number Rockville Montgomery 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Hartford 1 🗓 M 2 🗆 F Months Davs Hours **Director** 041-16-0166 95 Feb. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6111 Montrose Road Apt. 220 20852 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 XWidowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Carpet Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Mary (unk) Joseph Grossman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural, Route Number City or Town, State, Zip Code) 10401~Grovenor~Place,~Apt.~160% North Bethesda, MD 20852 Deborah Katz - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 C Conation 5 Other (Specify) Fairview Cemetery 5-21-2012 West Hartford, CT Metropolitan Funeral Services 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5517 Vine Street, Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and trar Due to (or as a consequence of) attending physician at for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? After this certificate funeral director, pag 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Natural
Accident
Suich 5 \square Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: A pleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2 To the I

only one)

29b. Signature and title of certifier

32. Registrar's Signature

1801

Messon Tember CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Jefferson.

R172412

5 + .

29d. Date signed (Month, Day, Year)

ROCKY, 110, MD 20852

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			Registrar 1. Decedent's Name (First, Middle,	Last)		- 001	tinoatt	0, 0	·catr		2. Date of De	Reg. No ath		-	3. Time o	
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			2901 S. Leisure						r Spr				lont	gomer		
	Funeral Director			6. Sex 7. A	ge (In yrs. I 84	ast birthday)	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			g. Birthp Count	lace (State o ry)	or Foreign
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036	s afte ral", Exan	q pe	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	2110	1	I ☐ Yes	2 X No	Specify:	;			Specify:		White	
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2	ed wit Hygie other	Be C	12 17. Father's Name (First, Middle, La	et)		Homen	uake I		18 Moth	or's Name	e (First, Middle,	Maiden				
lan	be filk ked k	2	Yudel Charlonsk	*						ah K		Maidell	ourname			
Maryland	nould ind M s mar umat		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	l Route Numbe	er, City or	Town, St	ate, Zip C	ode)	
	d 2 sl alth a n 27 i		George Goldrich	- Husband		17 A1	Lton :	Place	e, Br	ook1	ine, MA	A 024	446			
ore	of He		20a. Method of Disposition 1 Durial 2 Cremation	2 Pomoval from Star		Place of Dispo			e)	[Date	20c. Le	ocation -	City or To	wn, State	
ij	Page ment tant		4 Donation 5 Other (Sp.	pecify)		aron Me	-			5-23	-12	Shar	con,	Ma		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mexial Hygiene. Important of Health and Mexial Hygiene Important of I item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Lie	ensee Edward	i Sage						nzansky , Rocky				ınd 20	852
	Han Current		23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final	lly one cause on each li	ne.				g, such as	cardiac c	r respiratory ar	rest,			Approxima Interval Bet Onset and	tween
	hysician Medical	97 9	disease or condition resulting in death)	a. End Sta			lseas	e						Y	ears	
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ita	nysician: The law nis certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital:				Othe	ce of Dea	ith (Check	(only one)		-37 Se	cond	Resi	dence
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Division of Vital	Attendi er death. ector: A by the fu	Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of I	njury - At ho etc. (Specif	ome, farm, str	eet, factory	, office		$\neg \uparrow$	28f. Location (r or Rural	Route Num	ber,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		Physician: To the best caminer: On the basis of												anner stated.
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			30. Name and address of person w	<u>/</u>	death (Iten	n 23a) (Type. F	Print)		-							
			Robert Fields,	MD 18109	Prin	ce Phi	lip D	r. #	200,	01ne	ey, Mar	y1an	d 20	832		
	Sta Registr	te ar	31. Date filed (Month PAY 2. 3	2012 32. legis	trar's Signa	ture	are	,								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 22 JENNIE ANN GRAY 2012 4:10A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 220-18-7509 1 ☐ M 2**X**XF 88 Yrs 04/21/1924 Maryland Usual Residence of Deced 10a State 10b. County 28a-f sho 10c. City, Town or Location 10d. Inside City Limits I ust be notified at Director Maryland Baltimore 1 Yes 2 (V) Towson the 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral filed within 72 hours after death with 1055 West Joppa Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, the Medical Examiner ò 1XXNever Married 2 Married Black, White, etc. 2 Baltimore, Maryland 21215-0036 1 Yes 2 XXVo Specify: Completed 3 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Technician Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Clifton Charles Gray Page 1 and 2 should be Jennie Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Lee Fisher Dorman Nephew Gristmill Court #403, Pikesville, Maryland 21208 20a. Method of Disposition
1 ☐ Burial 202 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date GreenMount Crematory :05/23/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Se vice Licens 22. Name and Address of FacMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1-12 disease or condition resulting in death) ay 3 Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-trans Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 🗆 No Yes 1 Tes Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? No No 잍 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 25014 Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the F 29b. Signaty

State Registrar

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES MO

32. Registrar's Signature

29c. License number

29d. Date signed (Month. Day, Year)

22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 9:50 AM B'Y EBONY GARRISON Mai 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland N/A Grenera If Under 24 Hrs. 6. Sex Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months Hours Min 28 Yrs Director 216-11-6514 MARYLAND 1984 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 XXYes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code items 23a or ner must be n ō 10g. Citizen of What Country? Funeral 826 W NORTH AVENUE 21217 U.S.A. APT C 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò ģ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 and Mental Hygiene.
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1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Day Month Year signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag. 2 No 1 🗌 Yes Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work' 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to-the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 19 harma romana

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

F BONY

lanc

30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012

		1	For State Registrar	State of IV	aryian	•	artment of F tificate of L			ental Hy	/giene Reg. No	201	2	16	5226
	Dhysicia	/	1. Decedent's Name (First, Middle,	Last)						2. Date of De				3. Time o	of Death
	Physicia Medio		ROBERT A. GLE							Month May	19 Da	201	ar 2	1:5	9 p M
	Examin	er	4a. Facility Name (if not institution, g	•			4b. City, Town, or	r Location	n of Death			. County of D	eath		
*=	<u> </u>		Laurel Regior 5. Social Security Number 6				Laus If Under 1 Year		04 l t T			rince			
	Funeral Director		577-40-3143 Usual Residence of Decedent	1 X M 2 □ F	e (in yrs. ia 81	ast birthday) Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, Date Aug • 2		g. 1930 Wa	Birthpla Country ashi	ace (State y) ngto	or Foreign n, DC
	and show	ē	10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside (City Limits
	Maryla 8a-f	Director	MD Prince	George's	L	aurel								1XXX Ye	s 2 🗆 No
	the land	٥	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What	Countr	y?	
	n with	Funeral	200 6th Stree	t			2070	7				US	SA		
	deat riten inerr		11. Marital Status	12. Was Decedent Armed Forces?		5. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic O ın, Mexica	rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)	. [14. Race - A Black, W			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 ☐ X Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 X ☐ If Yes, Give Year or Dates.	No		☐ Yes 2 ☐XNo					Specify:			
5-0	2 hou "natu edica	plet	15. Decedent' (Specify only highest	s Education grade completed)		16a. Deced	ent's Usual Occupa	ation durina mo	st of working	7	16b. K	(ind of Busine	ss Indu	stry	
121	ithin 7 ene. • than he Me	Completed	Elementary/Second <i>a</i> y (0-12) 12th	College (1-4 or 5	5+)	life. DO	O NOT use retired)			,	7.7-				
Q 0	Hygin Other ent, t	Be (17. Father's Name (First, Middle, Las	<u>~</u>		Su	pervisor	18 Mot	her's Name /	First, Middle,	•	ste Mar	nage	ment	
lan	be fi lental rked lic ev	To	Leroy Glenn						arl St		maidon	Garriarrio			
ary	hould and IV s ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a				er, City or	Town, State,	Zip Co	de)	
	nd 2 sealth an 27 i		Sara W. Glenn/W	ife		200	6th Stree	et,]	Laurel	, MD	2070	7			
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ KCremation 3	Removal from State		lace of Dispos	sition (Name of natory or other place	e)	Da	te	20c. L	ocation - City	or Tow	n, State	
ţ	t. Pag tment tant: jury c		4 Donation 5 Other (Spe			st Aru	ndel Cre	n.	5/22/	2012	Od	denton	, MI)	
Baltimore,	permit Depar Impor any in once.		21. Signature of Funeral Service Lic	A W	моіі		. Name and Addres					neral E	Home 0707		Α.
П			23a. Part 1. Enter the disease, or co shook, or heart failure. List onl	omplications that caused	the death									Approxima	
~	Physician/	1 2	Immediate Cause (Final disease or condition	=191		ral Ef	fusion							nterval Be Onset and	
	Medical Examiner		resulting in death)	Due to (or as		,									
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as		Cance	Ţ						+		
100	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury			,									
7)	death certificate be executed ne attending physician and ed for use as the burial-transit	EX	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):		-					\top		
2092	ite be hysicii he bu	edical	•	d									\bot		
687	irtifica ling pl e as t	/Me	IF FEMALE:	00 1/											
Box (attending for use as	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)	у				23d. Date of Month			Year
W	he de	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	g Unknown	t tillie of di	eath J	Other (specify)							ω,	
<u>0</u>	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death b	ut not resu	Ilting in the ur	nderlying cause give	en in Par	t I.	23e. Did t	obacco u	ıse contribute	to the	cause of o	death?
ds,	quires en sign uld be	edk	Neutropen	<u>i</u> a						1 🗆	Yes 2	□ No 3 □	Proba	bly 4 🛚	Unknown
Division of Vital Records,	The law requires that the ate has been signed by the page 2 should be detach	Completed								24a. Was		24b. Were	autops	y findings pletion of a	available cause of
Вe	sician: The law scrifficate has t									perfo	ormed?	death			
ţ	iding Physician: 1 th. After this certifica funeral director, p	m	25. Was case referred to medical examiner?	Hospital:					ath (Check o	nly one)					
<u>></u>	Phys	은	1 XYes 2 No 27. Manner of Death	1 Inpatie		ER/Outpatient 28b. Time of	3 DOA Othe	4 L N				Other (Sp	ecify)		
o L	nding th. : After e fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day	Year)	injury	work?	Yes 2	1	d. Describe h	now injury	y occurred			
Sic	Atter er dea ector by the	Certificate:	3 Suicide 6 Could no	be 28e. Place of Inju	ry - At hor	ne, farm, stre						d Number or i	Rural R	oute Numi	ber,
<u>≥</u>	tal or rs afte al Dir			building, etc	. (Specify)				-	City or Tov	vn, State))			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director,	Medical	(Check 2 La Medical Exa	nysician: To the best of miner: On the basis of ex	kamination	and/or investi-	gation, in my opinior	n, death c	occurred at th	e time, date a	and place.	, and due to th	ne cause	(s) and ma	anner stated.
	To the vithir comp		29b. Signature and title of certifier	urse Practioner: To the	Dear OI IIIY	miowieage, a	29c. License		е апа расе,	and due to th		s) and manner te signed (Mo			
			> Yell !!	ll MD			D00	708	42		5/1	9/20	12		
	30		30. Name and address of person wh	completed cause of de			,	2022	T 2	ol wr	- [`	t	(-1		
	State Registra	_	31. Date filed (Month, Day, Year) MAY 2 3 2012	32. Registra	r's Signat	re	n Dusen R	waa,	Laur	eı, ML	20	0707			
	riogistia			Marine 10	. //										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY EDITH SELMA GORDON 2012 16 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min. Director 079-18-6080 1 □ M 2 X F 88 11/24/1923 NY or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector BALTIMORE TIMONIUM 1 Yes 2X No 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 POT SPRING ROAD 21093 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER EDUCATION of Health and Mental Hygi Item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment. Important: If Item 27 is marker-eny injury or and **EDWARD** MEILMAN ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY J. GORDON/DAUGHTER BARTHEL COURT, LUTHERVILLE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3🛣 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR PARK CEMETERY : 05/20/2012 PARAMUS, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) repronder Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death g | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 N 1 Yes 2 🗆 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, on! one) 3 🗌 Certil ring Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and time of cer 00 10. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	arylan	d / Depa	artment of F	lealth a	and M				2 162	28
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Cer	uncate of L	- au i		2. Date of De	Reg. No.		3. Time of De	aath
	Physicia		BARBARA	,	GHG	GENHEI	М			Month	17 Day	2012	12:45	
	Medic Examin		4a. Facility Name (if not institution, give	street and number)	000	OLIMILL	4b. City, Town, or	Location of	f Death	11111	1	County of Dea		Α
			725 MT. WILSON	LANE, APT	. 72	7	BALT	CIMORE	Ξ			BALT	IMORE	
W	Funeral		5. Social Security Number 6. S			ast birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birl	th v Vear)	9. B	rthplace (State or F	-
-	Director		130-24-1310	LIM 2 to F	91	Yrs.	Months Days	Tiodis	141411.	08/06	7192	0 0	GERMA	NY
	how at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation						10d. Inside City	Limits
	arylar a-fsl fied	Director	MD BALTI	MORF		BALTIM							1 ☐ Yes 2	
	or 28		10e. Street and Number	IORE		DILLITI	10f. Zip Code				10g. Cit	zen of What C	ountry?	
	with size	Funeral	725 MT. WILSON	LANE, APT.	727		212	208				USA		
	items er m	Fu	11. Marital Status	12. Was Decedent Ev	ver in U.S		Vas Decedent of Hi Yes, specify Cuba	spanic Origi	in? (Spec	ify Yes or No-	T	14. Race - Am		
36	", or amin	by	1 Never Married 2 Married	Armed Forces? 1 Yes 2 1 If Yes, Give	Vo		Yes 2 XNo		T derto i	iicari, 6tc.)		Black, Whi Specify:	te, etc.	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 Widowed 4 XDivorced	Year or Dates.									WHITE	
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72	vithin liene. r tha	ပ္ပ	Elementary/Seconday (0-12)	College (1-4 or 5-	+)		OKKEEPER				MAC	Y'S CR	EDIT DEPT	,
ğ	ent ent	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,				
/lar	uld be fil Mental narked aric eve	70	KURT		UNK	NOWN		OLG	GA				UNKNOWN	
Maryland	shou and is m		19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Address (Street a	and Number	or Rural	Route Numbe	r, City or	Town, State, Z	ip Code)	
	and 2 and 2 em 27		ALLAN BRULL/NEP	HEW		220	4 SUGARCO	ONE RO	OAD,	BALTIM	ORE,	MD 2	1209	
ore	t of H If ite or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	C C	emetery, crem	sition (Name of natory or other plac	e)	Da	ate	20c. Lo	cation - City o	r Town, State	
Ę.	t. Pag tmen tant: ijury		4 Donation 5 Other (Special	(y)		COPGE E	R BALTIMO	ORE C)5/20	/2012		BALTI	MORE, MD	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens	see			. Name and Addres		201				., INC.	
			23a. Part 1. Enter the disease, or com	plications that caused	the death		900 REIST					VILLE.	MD 2120 Approximate	18
١.			shock, or heart failure. List only o		the death	i. Do not ente	i the mode of dying	g, 30011 d3 0	ardiac or	respiratory an	1031,		Interval Betwe	
	Medical		disease or condition resulting in death)	a. Due to (or as a	-								one wer	_k
	Examiner			Mulla	le.	C 1	L-0515						20 year	rs
		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequ									
Þ.	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events	C										
,	ate be executed hysician and the burial-transit	al E	resulting in death) Last	Due to (or as a	consequ	ence of):								
Box 68760	cate be physic the b	edical		d										
687	eath certifica attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome o	of pregnar	ncv						20 D-1(-1	P	
ŏ	atten atten for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at	2 🗌 Feta	Ideath 3	Ectopic pregnanc Other (specify)	У				23d. Date of d Month	Day Yea	ar
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Records, P.O.	r equires that the de Leen signed by the sinould be detached	by P	Part II. Other significant conditions of	ontributing to death bu	it not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	obacco u	se contribute t	o the cause of deal	th?
ds,	quires en sig alld b	ed								1 🗆	Yes 2	₩o 3 🗆	Probably 4 🗌 Un	known
Ö	haster haster je 2 sho	Completed								24a. Was		24b. Were a	utopsy findings ava	ilable se of
Fle	Tela vaeho pge	Con								perfo	rmed? 2 ₩ No	death?	es 2 No	
ta	certifica ector, p	Be (25. Was case referred to medical examiner?	t leawitel.				ace of Death	(Check	only one)				
<u> </u>	Physi this c al dire	2	1 Yes 2 No			ER/Outpatien		4 ∟ Nur	1			Other (Spe	cify)	
0	ding P	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		28b. Time of injury	28c. Injury work		- 1	8d. Describe h	now injury	occurred		
Sio	I or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b		ov = At hou	me farm stre		res 2 🗆 I	-	8f Location /9	Stroot and	1 Number or B	ural Route Number,	
Division of Vital	after Dire		4 ☐ Homicide determined	building, etc.	(Specify)	, 10,111, 000	ot, lactory, office			City or Tou		Tramber of Tr	arar noate rvamber,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		sician: To the best of n										
	the H(lin 24 he Fu rplete	Mec		ner: On the basis of ex se Practioner : To the b										er stated.
	To t To t		29b. Signature and title of certifier				29c. License				29d. Dat	e signed (Mon	th, Day, Year)	
			A Vh	M			1938	3675			Mar	17	2012	
	01		30. Name and address of person who o	_				u	ΩΛ.	Trach		010		
	Stat		JOEC MESKULAM 31. Dates (Hard Month, Baku/par)	30 \ 32. Regis r rar		AUC 1	C # 80	7	17176	11 LOKIN	·>	21202		
	Registra		31. WAY 203, 2012 A	32. Registrar	Ga	Red								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month Year **Physician** DWARD /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ₹M 2 □ F Days Hours Maryland 215-18-7272 90 Director 25, 1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No Director Md. Baltimore City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 437 Imla Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify ۵ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Factory Worker Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Goldsmith Anna Urbanski ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Jecelin-Daughter 472 Wiley Road Delta, Pennsylvania 17314 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St.Stanislaus Cem 18, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Se M00933 Toha Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) . ⊮Medical Due to (or as consequence Examiner Se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated even the control of the control o Examine FFICILE COLITIS The law requires that the death certificate be executed OSTRIDILLM physician and as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death
Unknown Day 5 Other (specify) the 9 Unknown signed by tall be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CON 6ESTI & 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has I 1 Tyes 2 **N** 2 🗌 No 1 TYes certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 ☐Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ၉ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) within 2 To the I

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EXEROLD, BO

29b. Signature and title of certifier

KEVIN

31. Date filed (Month, Day, Year)

29c. License number

4-31298

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

15

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month James Autry Graham 2012 May 9:14 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 211 Furrow Street Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Davs 232-60-5570 **Director** 1 🛛 M 2 🗆 F 73 06/16/1938 West Virginia Usual Residence of Decede show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD Baltimore 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a o the Medical Examiner must be Funeral 211 Furrow Street 21223 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. rmed Forces? X Yes 2 □ No. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7.4 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) General Contractor Construction Be Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Elnola Sulger other traumatic Sadie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Significant Other Department of Health ar Important: If item 27 is any injury or other trau Margaret Arnold 211 Furrow Street, Baltimore, MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State 05/22/2012 4 X Donation 5 ☐ Other (Specify) Anatany Gifts Registry Hanover, Maryland . Sig. at re of Fun ral Servic → L. ensee 22. Name and Address of Facility Anatomy Gifts Registry 1 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Physician/ METASTATIC LUNG disease or condition resulting in death) month Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Diss to for each nonsequence off requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached i g Unknown 9 Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law page 2 has autopsy After this certificate 1 Yes 2 No Yes 2 N 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending Natural n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fu 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical within 24 hou

To the Funer

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

State Registrar 400 CATON AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

George Hartman	State of Maryland 1- For State Registrar	d / Department or Certificate or	f Health and Mental f <i>Death</i>		eg. No. 20	12 1623
Physician Medical Examine	George William Hartma	an		2. Date of Deat Month May 17, 20	Day Year	3. Time of Death 0810 hrs
	4a. Facility Name (if not institution, give street and number 7940 Bank Street	er)	4b. City, Town, or Location of D Baltimore	eath	4c. County of D Baltimore (
Funeral Director	5. Social Security Number UN K 6. Sex 7, 7	Age (In yrs. last birthday) 28 Yrs		Min.		. Birthplace (State or or oreign Country) Maryland
and show any	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or Locat				10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho 10 Director	10e. Street and Number	Batelinole	10f. Zip Code	10	g. Citizen of What (Country?
after death wing, or items	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Ityes, Give Year or Dates:	2 X No 1	21224 s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu Yes 2 X No specify:	(Specify Yes or No- erto Rican, etc.)	U.S.A. 14. Race - Ar White, et	merican Indian, 8lack, c. White
5-0036 led within 72 hours Hygiene. In ther than "nature the Medical Exami Committed I		or 5+) during me	t's Usual Occupation (Give kind ost of working life. DO NOT use t Cutter	retired)	16b. Kind of 8usine Restau	
P ≥ ₹ 3 € C	George William Hartman	19b. Mailing		ame (First, Middle, Manager) A Lee Howard Route Number 1	ard	tate. Zip Code)
MD nd 2 sho alth and m 27 is	Sandra Lee Howard / Mothe	P.O. 20b. Place of Dispos	Box 644, Winc			
Baltimore, permit. Pages 1 at Department of He. Impurtant: If ite	1 Burial 2 Cremation 3 Removal from 5 4 X Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Anatony Gif	· · ·	5/23/2012 Anatomy (Hanover, Gifts Reg	Maryland istrv
Physician	23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	75 ed the death. Do not enter th	22 Connelley D	r., Ste. 1	P,Hanover	
/Medical Examiner		e and Alprazo	lam Intoxicati	on	<u> </u>	Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.	nsequence of):				
executed an and al - transit						
sici be	IF FEMALE: 23c. If yes, outce 23b. Was decedent pregnant in the	a,27,28a-f,pe	er me,g928 6-1-	·12 sm	23d. Date of deliv	very
D. Box 68760, the death certificate be the death certificate be by the attending physiciched for use as the builded for the builde	1 Yes 2 No 9 Unknown 9 Unknown	at time of death 5 Oth	al death 3 Ectopic pre		Month	Day Year
ds, P.O. quires that the en signed by uld be detach		ath but not resulting in the u	nderlying cause given in Part I.	1	2 No 3 F	to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 6876 the Boptial or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy appletely filled in by the funeral director, page 2 should be detached for use as the lical Certification: To Be Completed by Physician/M.			26.Place of Death (Che	autops perform 1 ✔ Yes 2	y prior ned? death	
1 of Vital ling Physician After this cert funeral directon On: To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpat	ient 2 ER/Outpatient	3 DOA Other Nu	sing Home 5 F	Residence 6 Of	her: Scene
Division o spital or Attending tours after death. meral Director: After filled in by the fune Certification:	1 Natural 5 Pending 2 X Accident Investigation 3 Suicide 6 Could not be (Month, Day	,Year)	Oam 1 Yes 2 X No	subject narcotic	took not s and benz reet and Number or	prescribed zodiazepines Rural Route Number, City
Divis To the Hospital or A within 24 hours after The the Funeral Dire completely filled in b edical Certific		ound: Residen		Baltimo		
To the Hos within 24 h Tha the Fun completely	one) 2 Medical Examiner: On the basis of exam and manner stated 29b. Signature and title of certifier	amination and/or investigati	on, in my opinion, death occurre		nd place, and due to	
	30. Name and address of person who completed cause of	death (Item 23a)	O.C.M.E.		May 17, 2012	
State	Ana Rubio MD. Assistant Medical Exa	, ,	more Street, Baltimore,	MD 21223	· · · · · · · · · · · · · · · · · · ·	
Registra	0.0040	A. park	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b c per fh 8927 5-24-12 yr State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Lauretta Harvey 2:19 PM 05 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FRANKLIN SQUARE MEDICAL CENTER ROSEDALE BALTIMORE 6. Sex 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 217-24-3954 Director 82 1 M 2X F 04/13/30 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7522 Rossville Boulevard 21237 USA or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Reed's Drug Store Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha Professional Cook 11th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dennis Fisher Mary Elizabeth Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 2607 Camelback Ln. Unit 10 Silver Spring MD. Gwendolyn Henderson 20a. Method of Disposition 20c. Location - City or Town, State **Hanover** Balto Maryland 20b. Place of Disposition (Name of Arden Corons 2^{Date} 12 1 Burial 2 Cremation 3 Removal from State Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore MD. 21206 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence of) ISCHEMIC CARDIOMYO PATHY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Pregnant at time of death Dav Year the 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

HARVEY, LAURETTA

Completed by page 2 Be မ

Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be

this certificate has

After

To the Funeral Director: completely filled in by the

within 2 To the I

death.

Records, P.O. Box 68760

Division of Vital

STENOSIS INSULIN DEPENDENT DIABETES MELLITUS

24a. Was an autopsy performe Yes 2 No Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred

1 🗷 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one)

29b. Signature and title 29c. License number

2012

30. Name and address

completed cause of death (Item 23a) (Type, Print ROAD 6918 RUGE MARYLAND BALLMORE

Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G928 6/20/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20 Physician/ Month Robert Nathaniel Hayward Sr. 05 2012 8:20P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A 5. Social Security Number 9209 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 83 1 ★ M 2 | F 07/10/28 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f Maryland Baltimore 1 🔀 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2714 Guilford Avenue 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Bace - American Indian "natural", or iter dical Examiner Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married X Yes and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Yes. Give 3 Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Balto.City School Elementary/Secondary (0-12) College (1-4 or 5+) Supervising Custodian System 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unknown Dorothy Hayward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada Nichols 4407 Moravia Rd.Apt.11 Baltimore MD.21206 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of harmonic of harmonic or fitter any injury or or once. $05 - 2^{\text{Dete}} - 12$ Page 1 1 X Burial 2 Cremation 3 Removal from State Maryland Nal t Mem. Park Laurel, Maryland 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore, Maryland 21206 arre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Urosepsis Medical resulting in death) Due to (or as a consequence of) **Examiner** septic shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 2 × No Hospital Other: 1 Yes မ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 5 Pendina Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours a Funeral L Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/20/2012 AT 2438946 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dave Bulger 201 East University Parkway, Baltimore MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 2 3 2012 A. pare Registrar

DHMH 17 Rev 06-2011

12-03764 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Larry Stephen Hicks, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 16234 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 16, 2012 **Medical Examiner** Larry Stephen Hicks, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Old York Road & Openshaw White Hall **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Months Days Hours Director 1 X M 236-13-3722 03/29/1965 2___F 47 Usual Residence of Decedent in 10a, State 10b. County 10c. City, Town or Location 23a or 28a-f show notified at once. Harford Joppa Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f sho ro other traumatic event, the Medical Essening must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1904 Mountain Road 21085 Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year 1986–1989 4 Divorced 1 Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Seal Master Baltimore Truck Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Larry Stephen Hicks Retha Arlene Dooley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print.) 1904 Mountain Road - Joppa, Maryland Terry M. Hicks (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 05/22/2012 Baltimore, Maryland Metro Crematory, Inc. 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses E. F. Lassahn Funeral Home, P.A 11750 Belair Road - Kingsville, Maryland 00 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician /Medical failure. List only one cause on each line. a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been s page 2 should b 24a, Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? 25. Was 8 exam ဥ 1 🗸 27. Mani Certification: 1 ___ N 2 🗸 A

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, filled in by the funeral within 24 hours after death.

To the Funeral Director:

					1 ✓ Yes 2 No	1 Yes	2 No
25. Was case referred to medical			26.Place	of Death (Check	only one)		
examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursi	ng Home 5 Residence	e 6 🗸 Other; Scer	ne
27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Month, Day Year) May 16, 2012	28b. Time of Injury 2329 hrs	,	ry at Work? Yes 2 ✔ No	28d. Describe how injury Operator of motorcy		collision
3 Suicide 6 Could not be determined	28e Place of Injury - At he		28f. Location (Street and or Town, State) Old York Road & Oper				
29a Cartifier							

29a. Cer Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E. May 17, 2012 30. Name and address of person who completed cause of death (Item 23a)

900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD Assistant Medical Examiner

31. Date filed (Month, Day, Ye. **NAY 2 3 201**)

Medical

State Registrar

32. Registrar's Signature

2333 hrs

Country) Virginia

10d. Inside City Limits

1 Yes 2 X No

21087

Approximate Interval

veen Onset and Death

Year

9. Birthplace (State or Foreign West

White

Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James George Holmes, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Regional Hospita aurel _aure Prince George Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Months Hours Min Illinois 1937 75 Director 328-30-1849 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8612 Kiama Road 20708 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Armed Forces?

1 X Yes 2 N 1956-14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 1959 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Elementary/Seconday (0-12) College (1-4 or 5+) Traffic Analyst Security Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H James George Holmes, Sr. Fannie Maude Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Harriet Holmes / wife 8612 Kiama Road, Laurel, MD 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/24/2012 Ivy Hill Cemetery Laurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave, Laurel, MD 20707 M01581 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Septic Shock Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Pneumonia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 | Yes Z | g | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic Lung Cancer Records, 1 X Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No Yes e Hospital or Attending Physician; 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Other: ပ္ Minpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 7300 Van Dusen Road Laurel, MD 20707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital Ali Goji, MD Nega 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:30 AM vangeli 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Nottinghan Kolling Vista altimore Court 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Min 1 M 2 W Hours Director Jsual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f s 1 Tes 2 No Nottingham Himore 10g. Citizen of What Country? 9 23a Funeral 21236 permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must I 11.54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Never Married 2 Married 1 Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, PONOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ arlie took ns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 19a. Informant's Name/Relationship (Type, Print) ethia sta Nothrahau. MD Kolling tolt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State attimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line 22. Name and Address of Facility Howel ehms KK. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final CONGESTIVE Physician/ HEAR disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or a conseque ce of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the IF FEMALE: nse 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ō Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ RENAL Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 **N**O ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in trip opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 134041 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLYD. BALILMORS

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26,28e, perPHYS, G927,572372012, WS

State of Maryland / Department of Health and Mental Hygiene 16237 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 04^{Month} Physician/ IT ENSON 26 2012 9:35A Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death 7701 Meath Ct. Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 M 23 Maryland 219-12-3830 88 Yrs Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director MD 1 Yes 2 XNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8028 Solley Rd. 21060 U.S.A death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: Black 3 Swidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. 12th Grade (0-12) College (1-4 or 5+) 2 should be filed with and Mental Hygien 7 is marked other the Housewife other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clayman Spencer Alice Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or 2 Teresa Johnson(daughter) 7701 Meath Ct., Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Cem. 05/02/12 Crownsville, MD 21. Signature of Funeral Service Licenses For Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 a Prt 1. Erse the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between In rediate Cause (Final Onset and Death Dementiq Severe Physician/ 04 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequ Examir and Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Daughter's Hospital 2 **M** No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) House this eral Director: After the filled in by the funeral 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No hours after death 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a **To the Funeral C**completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practioner: To the best of my in 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D14136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALJIT 5. SAW HN EY 610 CT Cum Trivers MAY 2 3 2012 State Registrar

Physician/ Medical

Examiner

Funeral

Director

17. ပ

Be Completed by Funeral Director

	Pleas	e Type or Pr	int in Black	k Ind	delible Inl	k. Ensu	re Al	II Copies	Are I	Legible.	
For State Registrar		State of M	laryland / Do		rtment of F		nd M		iene	2018	2 16238
Decedent's Nam	ne (First, Middle, L	.ast)	`	50,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2. Date of Deat	:h		3. Time of Death
LAUR	A E. JOH	INSON						Month 65	22	Zol2	01:09 AM
4a. Facility Name (ii	f not institution, gi	ive street and number)			4b. City, Town, o	r Location of I	Death		4c. C	ounty of Death	1
UNION M	EMORIAL	HOSPITAL			BALTIM	ORE CI	TY			N/A	
5. Social Security N 215–44–1	120		ge (In yrs. last birtha 65 Yr		Months Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Day, 5/28/19	Year)	Cou	hplace (State or Foreign Intry) YLAND
Usual Residence 10a. State	of Decedent 10b, County		10c. City, Town o	or Loca	ation						10d. Inside City Limits
MD	N/A	1			RE CITY						1X Yes 2 □ No
Oe. Street and Nu					10f. Zip Code				10g. Citize	en of What Co	untry?
2626 на	MPDEN AV	ENUE			2121	7				USA	-
1. Marital Status		12. Was Decedent		13. Wa	as Decedent of H	lispanic Origin	? (Spec	cify Yes or No-	14	I. Race - Amer	
1 Never Man	ried 2 🗆 Married	Armed Forces? 1 Yes 2 X If Yes, Give			Yes, specify Cuba □ Yes 2 🙀 No		ruerto n	ncan, etc.)		Black, White	, etc.
3X☐ Widowed	10.00	Year or Dates.			21				5/	pecify: WHI	TE
(Spe	15. Decedent's ecify only highest		1 (0	Give kir	nt's Usual Occup nd of work done	during most of	f workin	99	16b. Kind	d of Business/l	ndustry
Elementary/Sec		College (1-4 or	5+)		NOT use retired) FMAKED				O.	√N HOME	1
7. Father's Name		t)	I		EMAKER	18. Mother's	s Name	(First, Middle, N			,
WILLIAM								. WHITE		,	
19a. Informant's N			19b. N	Mailing	Address (Street	and Number o	or Rural	Route Number,	City or To	own, State, Zip	Code)
JAMES W.	JOHNSON	I/SON	I .	_	ROLAND A			LTIMORE		21211	
0a. Method of Dis	position	7	20b. Place of D	Disposi			Di	ate	20c. Loca	ation - City or	Town, State
1 ∐ Burial 2 4 ☐ Donyation		Removal from State			MATORY,		5/20	6/2012	CATO	ONSVILL	E, MD
21. Signatur of Fu	Ineral Service Lic	MOT	139	22.		ss of Facility	THE	JOHNSO	N FUI	VERAL H	IOME, P.A.
23a Part 1. Enter	the disease, or co	on plications that cause one cause on each lin	d the death. Do not								Approximate
Immediate Cause	(Final	Pone cause on each in	li sensi	2							Interval Between Onset and Death
resulting in death)		a. Due to (or as	a consequence of):	7							
		septi	c shoc	k							
Sequentially list co if any, leading to in cause. Enter Unde	nmediate	Due to or as	a consequence of								
Cause (Disease or Chat initiated event	injury	C									
resulting in death)		Due to (or as	a consequence of)	:							-
		d									
F FEMALE:	7.7								- 1		
3b. Was decedent in the past 12			2 Fetal death		Ectopic pregnand	су			23	3d. Date of del Month	ivery Dav Year
1 Yes 2	X No	4 ∐ Pregnant 9 ☐ Unknown	at time of death	5 🗆	Other (specify) _					WOITH	Day real
		contributing to death	but not resulting in t	the un	derlying cause giv	ven in Part I.		23e. Did tol	pacco use	contribute to	the cause of death?
								1 □ Y	es 2 🛭	No 3□Pr	robably 4 🗆 Unknown
-								24a. Was a			opsy findings available
								24a. was a autops perfor	sy		completion of cause of
F \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	rod to medical	T					(0)	1 Yes			2 🗆 No
5. Was case referr examiner? 1 \sum Yes 2	4	Hospital:			Oth	er:			,	7.00	
1 ☐ Yes 2	th	1 2 Inpat	tient 2 ER/Outp		3 DOA 28c. Injur	4 L Nurs		me 5 Reside			ify)
1 Natural 2 Accident 3 Suicide	5 Pending Investigat 6 Could not	ion	ay, Year) inju	ury	M 1 🗆		lo				
4 Homicide	determine	28e. Place of In	jury - At home, farm c. <i>(Specify)</i>	1, stree	t, factory, office		2	28f. Location (St City or Town		Number or Rui	al Route Number,

Medical Certificate; To Be Completed by Physician/Medical Examiner

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

]	(adra	L. (ooly	, 1	MU	

AT 2438946

29c. License number

29d. Date signed (Month, Day, Year) 05/22/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore MO 21218 201 East University Parkway, Candice L. Cody, MD;

State Registrar 31. Date filed (Month, Day, Year) MAY 23

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month Bernard Α. Jaworski 9:10PM Medical mn 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death AIN HEALTHAW) REHASILITATION HARFORD Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 Months 212-18-9665 91 Ma^{Month}6^{Day}1^Y9'21 Maryland **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Md. Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1236 Chateau Green Court 21015 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fire Fighter City of Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Jaworski Viola Pacanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Jones -Daughter 1236 Chateau Green Court Bel Air, Md,21015 20a. Method of Disposition 20b. Place of Disposition (Name of May Date 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Garrison ForestVA 29,2012 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A 21. Signature of Funeral Service Licensee M00933 146 Dunda1k Avenue Baltimore that caused the death. Do not en 23a. Part 1. Enter the disease, or complication Approximate Interval Between shock, or heart failure. List only one call Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) weel Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) attending physician Physician/Medical for use as s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death detached signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law page 2 autopsy perform death? After this certificate Yes 1 A Yes Vita 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) No the roop—

within 24 hours after death.

To the Funeral Director. After this of 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pract ner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and litle State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2 Date of Death Physician/ nold May 2012 0032 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Northwest Randallstrum Baltimore Courty 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Min 097264 Maryland unk °1°951 60 **Director** Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD N/A 1x Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Examiner must be 23a Funeral 648 Charraway Rd. 21229 U.S.A. items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ö ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: 'natural", Specify: Black Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) unk College (1-4 or 5+) Surgical Mercy Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be Health and Ment Clarence O. Jones Doris Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Janay Taylor(daughter) Chins Ct., Owings Mills, MD 21117 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State -17-12 on-site Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore,, MD 21. Signal re of Funeral Service Licensee 30 seph offs of by own Jr Funeral Home any. 2140 N. Fulton Ave., Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest block, or head allure. List only one cause on each line. Interval Between Innediate Cause (Final Onset and Death Physician/ entrucular sease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami thursclekohc burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ped the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 certificate 2 🗆 No 1 Tyes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Randallstown, MD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month O:SY AM May masn 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death +05 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year **Funeral** Age (In yrs. last birthday) Hours Director 471-30-1007 1 ☑ M 2 ☐ F 79 09/26/1932 Washington 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shoilary or other traumatic event, the Medical Evarilher must be recitived at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 5008 Barkwood Place U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Asian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Administrator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kichiji Kumagai Yaso Shimakawa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5008 Barkwood Place, Rockville, MD 20853 Setsuko Kumagai / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1
Department of
Important: If It
any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 M Donation 5 ☐ Other (Specify) 05/22/2012 Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that banked the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician Acute renal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pulmonary Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of): Exam attending physiclen and I for use as the burlal-trensit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached t 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 Yes 2 | No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မှ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 3 Suicide 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hristin cland 31. Date filed (Month, Day, 2. Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2005 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical Center Bultimore University Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 049-30-9954 Oueen Village 72 **Director** 1 🗙 M 2 🗆 F 10/31/1939 New York "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director York York PA1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3341 Appleford Way 17402 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Manufacturing Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) thent of Health and Mental Health and Mental Hant: If item 27 is marked of 2 Alfred E.Keough Mary Chaisson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M.Keough 3341 Appleford Way York, PA.17402 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Saviour Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 05-25-12 York, PA. 17406 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore, MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Desteremia Medical resulting in death) Due to (or as a consequence of): Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗌 No 1 Tyes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မှ 1 MInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12195325 CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

ADAM

31. Date filed (Month, Day, Year)

SHEELY

22 S. Greene St.

Boltimore

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 2012 Robert Emil Krissoff 03:47 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 578-36-5846 83 Director 1**X** M 2 □ F 12-20-1928 NJ Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Silver Spring MD Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 9 10g, Citizen of What Country? items 23a or ner must be r Funeral 20901 United States 915 Caddington Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. No Korean ò 1 X Yes 2 If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural". Specify: 3 X Widowed 4 Divorced White Completed Conflict the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked of
traumatic ever age 1 and 2 should be file ent of Health and Mental ent of Health and Merkal out: If item 27 is marked or y or other traumatic ew ၉ Rebecca Cohen Abraham Krissoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Krissoff - Son 612 Bay Hills Drive, Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) permit, Page Department Important: It any Injury or Judean Mem. Gardens 5-20-2012 Olney, Maryland 4 Donation 5 Other (Specify) Brian Deibler Danzansky-Goldberg 22. Name and Address of Facility ugen 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) I ast Examine Due to (or as a consequence of) attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Hypercalcemia 24a. Was an page 2 performed? Accute Chronic Kidney Disease - Stage 3 this certificate 2 No 1 Yes 2 X No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certificate: To 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending X Natural iours after death.

Ieral Director: Ai

filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 5-17-2012

Registrar /DHMH 17 Rev 06-2011

State

Jonathan Duran, MD - 1500 Forest Glen Rd., Silver Spring, Maryland 20910

· C. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D66249

SUDIE atient known as

> Box 68760 P.O. Division of Vital Records,

amend #20b,per fh,g928 6-8-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month 5 Physician/ 12.28 PM 20 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY INAI HOSPITAL OF BACTIMORE 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6244 Hours Min **Director** 1 M 2 M J 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location Medical Examiner must be notified at Director Baltimore 1 Yes 2 No 10f. Zip Code 21216 10e. Street and Numb 10g. Citizen of What Country? 23a Funeral runa "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 🗌 Never Married 2 🗆 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done Guring most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me ary (0-12) College (1-4 or 5+) rovider Be 2 Baltimore, mo Mt.Carmel 20a. Method of Disposition 20b. Place of Dispositio Burial 2 Cremation 3 Removal from State -26-12 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dehydration severe Due to (or as a consequence of). attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Month Dav ed by the a 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ Dementer Malnowishment 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Ducan 24a. Was an autopsy within 24 hours after death.

To the Funeral Director, After this certificate has I completely filled in by the funeral director, page 2: performed' 2 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 0 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number RES 000 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJEEV GUPTA, SINAI HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 1:25 AM 2012 Thomas Patrick Kelly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Hours 1 **X** M 2 □ F 56 Jan 08, 1956 Michigan **Director** 458-06-7857 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 No Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 21009 United States 2900 Brightwater Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner r Black, White, etc. Ď 1 Never Married 2 Married Yes. Give 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Ikea Stock Control Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked of ၉ William John Kelly Dorcas Evalena Liffick other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michelle Kelly /Daughter 2900 Brightwater Lane Abingdon, MD 21009 Department of Health
Important: If item 2
any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State May 19 Beltsville, Maryland 4 Donation 5 Other (Specify) 2012 Chesapeake Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between 3 Onset and Death Immediate Cause (Final Physician/ Monder Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to jor as a conse juence of Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Patrick es, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Thomas Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 / Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\superstyle{1}\) Yes 2 \(\superstyle{1}\) No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c, License number D0663220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE ISCUARUS
500 MPPER CHGSAPEAUE DR. BECATE MD 21014 CHESAPEAUE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician/ Manth 2012 6:40 PM ul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Months Hours Min. (Month, Day, Year) 04/24/1931 Yrs **Director** 197-24-1972 81 PA Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE RANDALLSTOWN 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3708 COLLIER ROAD and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗶 No Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 ★Widowed 4 ☐ Divorced Completed WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ္ SAMUEL FINK SADIE SABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 HEIDI DEITCHMAN/DAUGHTER 2054 STILLWATER ROAD, ELDERSBURG, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o once. 1 NBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 05/20/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licencee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. 1 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he at failure. List only one cause on each line. Immediate Cause (Final Onset and Death Bodies Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 5 Other (specify) Dav Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part £. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred Iniury ✓ Natural Accident 5 Pending 2 No Investigation after death Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) R08885Z CRUB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHUGGEN C. DIAMOND 2835 Smith AUGNUE #203 (SAUTIMONE, MANY INNS 21109)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Baltimore, Maryland 21215-0036	should be filed n and Mental Hy 7 is marked oth raumatic event	To Be	17. Father's Name (a		- Lawrence	e Lew	is				ame (First, Middle a Lewis		Surname)		
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imore	permit. Page 1 end 2 Department of Health Important: If item 27 any Injury or other t once.		4 Donation	Cremation 3 5 Other (Specif		C	lace of Disp emetery, cre YV1eV	matory or V Cre	other plac emat	ory	23/12	Ba.	ocation - C	MD	
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09	ath certificate be executed attending physicien and for use as the burlal-transit		resulting in death)		Due to (or as	a consequ	ence of):								
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Feyifiled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but after the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12, 1 ☐ Yes 2 i 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta	I death 3	☐ Ectopic		ey			23d. Date Mon		ery Day Year
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o uo	Attending F death. ctor: After y the funer	iicate	1 Natural 2 Accident	5 Pending Investigation	(Month, De		injury	М	work						
Division of Vital Records,	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filed in by the fu	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of In building, e			treet, facto	ry, office			n (Street a fown, Stat		r or Rura	l Route Number,
	ne Hospi in 24 hou he Funer pletely fil	Medical	(Check	2 Medical Exam	sician: To the best o iner: On the basis of se Practitioner: To t	examination	n and/or inve	estigation, i	n my opini	on, death occurr	ed at the time, dat	e and plac	e, and due	to the ca	ause(s) and manner stated.
	To the with commendation		29b. Signature and	d title of certifier	2			2	9c. Licens		57	29d. D	ate signed	(Month,	Day, Year) 2012
	61		30. Name and add		completed cause of	death (Item	23a) (Type	Print)	++	ns S	120	ltim	CYP	M	2012 D 21287
	Sta		31. Date filed (Mon			rar's Signa		. 10 1		114			-, -		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 16248 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 3:43 Edith Langer May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 210-32-0778 1 M 2 X F 79 10/04/1932 Germany 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f st notified 1 Yes 2 X No MD Ellicott City Howard 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral U.S.A 21043 2817 Montclair Drive Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Completed by 1 ☐ Yes 2 🗷 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced White Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bakery Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H Item 27 is marked of other traumatic evel မ Schnelder Paar Johann Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9146 Winding Way, Ellicott City, MD 21043 Susan Randt / Friend other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or ot Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/22/2012 4 X Donation 5 ☐ Other (Specify) Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licentee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Fetal 455.

Pregnant at time of death in the past 12 months?

1 Yes 2 No signed by the at id be detached for 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown RENAL CELL CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has aral director, page 2 autopsy performed? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \bigstar Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DANIEULE DOBERMAN IMD 31. Date filed (Month, Day, Year) 32 hègistrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



0336

064395

MAY 21, 2012

CEDAR LANE COUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_ynch	State of Maryland / Department 1- For State Certificate Registrar		Reg. No. 2012 162				
Physician/ cal Examiner	Decedent's Name (First, Middle,Last) Gary Alan Lynch	2. Date of Month May 2	Death 3. Time of Death 1858 hrs				
¥	Facility Name (if not institution, give street and number) Howard County General Hospital	4b. City, Town, or Location of Death Columbia	4c. County of Death Howard				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-76-8518 7. Age (In yrs. last birthday) 45	14 11 10 141	of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD				
th the Maryland 23a or 28a-f show any motified at once. al Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Woodbine 10e. Street and Number 1212 Adgate Court	10f. Zip Code 21797	10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country?				
rs after death wi ural", or items miner must be by Funera	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 No 1 No Parent Process 1 No Paren	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. Yes 2 X No specify: dent's Usual Occupation (Give kind of work done gmost of working life, DO NOT use retired)					
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nd 2 should alth and Me m 27 is ma aumatic ev	Cecelia Lynch - wife 1212	iling Address (Street and Number or Rural Route Adgate Court, Woodbin position (Name of cemetery, Date					
permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	1 X Surial 2 Cremation 3 Removal from State Crematory of Gate of I	other place) Heaven Cem. May 25 20	Silver Spring, MD				
permit. Departn Import	21. Igneture of Funeral Service Licensee 22	2. Name and Address of Facility Burrier- 1212 West Old Liberty R	Queen Funeral Home oad, Winfield, MD 27184				
received / saminer - transit - trans	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Multiple Injuries Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.		Death				
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oding Physi th. The After this funeral dir Ion: To	1 Matural (Month, Day Year) 1917 hrs	1 Yes 2 V No					
Hospital or Atteoding Physi A hours after death. Runeral Director: After this ely filled in by the funeral dir al Certification: To	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined See. Place of Injury - At home, farm, so (Specify) Major Road / Highw 29a. Certifier → Could not be determined See. Place of Injury - At home, farm, so (Specify) Major Road / Highw 29a. Certifier → Could not be determined See. Place of Injury - At home, farm, so (Specify) Major Road / Highw	treet, factory, office building, etc. 28f. Location Towwestbour	vn, State) nd Old Frederick Road @Alpha Road, Woodbi				
	1 Natural 5 Pending Investigation 2 № Accident Suicide Homicide Could not be determined Homicide Homicide May 20, 2012 1817 hrs May 20, 2012 1817 hrs	treet, factory, office building, etc. 28f. Location Town Westbour curred at the time, date and place, and due to the	nd Old Frederick Road @Alpha Road, Woodbi cause(s) and manner as stated.				

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ $20\overset{\text{Year}}{1}\overset{\text{Ze}}{2}$ Norman Lewis Levin 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fox Hill Assisted Living Bethesda Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Days Director 045-12-4094 88 1 X M 2 □ F 3-31-1924 Connecticut be filed within remember that the within remember than "natural", or items 23a or 28a most arked other than "natural", or items 23a or 28a most arked other than "natural", or items 23a or 28a most arked other than "natural", or items 23a or 28a most arked other than "natural". Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Chevy Chase MD 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Connecticut Avenue #625 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital_Status 14. Race - American Indian Armed Forces' Black, White, etc. δ 1 Never Married 2 X Married X Yes 2 No WWII Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Professor Higher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Joseph Levin Fannie Sosin other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health as Important: If item 27 is any injury or other trau 8100 Connecticut Ave., #625, Chevy Chase, MD 20815 Shirley Ginsberg Levin - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden Of Remembrance 5-22-12 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Days shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sici_n/ Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Advanced Dementia Years Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Alzheimers Disease Years Cause (Disease or injury and -trar that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical law requires that the death certificate be Box 68760 as the attending a IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached i Yes 2 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atherosclerotic Cardovascular Disease 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Atrial Fibrillation 24a. Was an autopsy perform this certificate has Hospital or Attending Physician: The I 24 hours after death.
Funeral Director: After this certificate h 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 XNo 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury X Natural 5 Pending Certificat 1 🗌 Yes 2 🔲 No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

МД

Roy Fried,

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7758

D34590

Wisconsin Avenue #211, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

5-21-2012

any injury or other traumatic event, the Medical Examiner must be notified at 28a-f items 23a Baltimore, Maryland 21215-0036 "natural", permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Physician/ Examiner -transit physician s the burial Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Neil Lafferty, Sr. 2012 Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4505 Arizona Ave Baltimore 5. Social Security Number 7. Age (In yrs. last birthday)
74 yrs If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 XM 2 🗆 F Days Months Min (Month, Day Year) 216-34-2015 1938 West Virginia **Director** Usual Residence of Decedent 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21206 4505 Arizona Ave United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give 1 ☐ Yes 2 🌠 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Machinist Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wilbur Lafferty Flossie Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lafferty /Wife 4505 Arizona Ave Baltimore, MD 21206 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 18 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematory 22. Name and Address of Facility Cremation and Funeral Alternatives Signature of Funeral Service License Heckeynor Rebecce 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death

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S Immediate Cause (Final CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Sand in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION CORONARY 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of DISGASE To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has E autopsy performed death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗆 Yes 2 🗀 No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D28987 completed cause of death (Item 23a) (Type, Print) 5601 LOCH RALDN BLUD SPERL M.D. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

naddeus Lupc)	State of Maryland / Department 1- For State Certificate	-	_	2012	1625
Physic	ian/	Registrar		Reg. N 2. Date of Death Month Day	3.	Time of Death
ledical Exam	iner	Thaddeus Lubo		May 19, 2012		2039 hrs
		Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth(MI	M/DD/YYYY) 9. Birthpl	ace (State or
Director		219-50-5352 1₺₩ 2□F 65	Yrs. Months Days Hours Min.	Dec 11	, 1946 Foreign Countr	Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		I 10	d. Inside City Limits
	L		ore City			Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country	?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fel and Mental Hygiewich. Department: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Dir	3217 Fait Avenue	21224		USA	
th with tems 2: If be n	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R		14. Race - American White, etc.	Indian, Black,
ter dea ", or if er mus	ᆵ	1 X Yes 2 No 3 Widowed 4 PDivorced If Yes, Give Year	Yes 2 X No specify:		Specify: Whi	te
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within giene.	E	12th 17. Father's Name (First, Middle, Last)	18.Mother's Name (I			Store
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Bec					
21 nould bed Men is mar	ᅙ		Ing Address (Street and Number or Ru			
MC 2 sl alth ar		Sandra Lupo DeMartin 321 20a. Method of Disposition 20b. Place of Disposition	7 Fait Avenue Ba	altimore	Md. 21	224 n. State
Baltimore, permit. Pages 1 an Department of Hea Important: If iten		1 W Burial 2 Cromation 3 Demoyal from State Crematory or	obsition (Name of cemetery, other place) Ville VACem 24			
it. Pag rtment ortant:		4 Donation 5 Other Specify:				•
Ba Derm Impo injur		21. Signature of Funeral Service Licensee M00933	2. Name and Address of Facility Kaca 201 Dundalk Aver	zorowsk:	l Funeral	Home,P4 d.21222
Physician		23a. Part I. Enter he disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	er the mode of dying, such as cardiac or r	respiratory arrest, si	hock, or heart A	pproximate Interval Setween Onset and
/Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Car	diovascular Diseas	e		Death
		or condition resulting in death) Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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. 68760, certificate be executed nding physician and ise as the burial - transi	ledical	✓ UNPENDED 23a,27,per me	,g928 6-5-12 sm			
876 tificate ng phy as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Live birth	Fetal death 3 Ectopic pregnance		3d. Date of delivery Month Day	Year
Box 68760, a death certificate be the attending physic ed for use as the bur	Physician/N	Pregnant at time of death 5	Other (Specify)			
• 4 ×4	Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	o use contribute to the	cause of death?
P.C	d by			1 Yes 2	No 3 Probably	4 🗹 Unknown
Division of Vital Records, P.(salor Attending Physician: The law requires that salbrector: After this certificate has been signed led in by the funeral director, page 2 should be dete	Completed	VI		24a. Was an autopsy		y findings available letion of cause of
eco he law ate has	d Ho			performed?	death?	2 No
n of Vital Reckding Physician: The law After this certificate ha fineral director, page 2	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check on	 		
F Vit	ם	1 Yes 2 No				
n of ading Pt. h. After a	<u>:</u>	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Death	of Injury 28c. Injury at Work? 21	8d. Describe how in	njury occurred	
r Atter er dear irector	ficat	2 Accident Investigation 28e Place of Injury - At home farm st		8f. Location (Street	and Number or Rural F	loute Number, City
Divis	Certification:	4 Homicide determined (Specify)		or Town, State)	10	
H 2 K 3		29a. Certifier (Check only The Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation.				ISA(S)
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and/or investigant and manner stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Month, i	
		() a. for Paris	O.C.M.E.		y 20, 2012	//
	ŀ	30-Marrie and address of person who completed cause of death (Item 23a)				
		Laron Locke MD. Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore, MD	21223		
St Regis	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature	4J			
176812	HEII.	1111 1	Y			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 22, Physician/ 2012 3:00 AMGladys L. McQuown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Frederick Homewood at Crumland Farms Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 💢 F Jan. 5, Year 1918 Pennsylvania 211-07-5220 94 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2904 Ward Kline Road 21773 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Completed by 1 \square Never Married 2 \square Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Pramco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emma Sankey William Bargerstock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 Ward Kline Rd., Myersville, MD 21773 (Daughter) Stacy Benner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X parial 2 Cremation 3 Removal from State Circle Hill Cemetery |6/2/2012 4 Donation 5 Other (Specify) Punxsutawney, PA 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Ho
9 Unknown Month 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 After this certificate has 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to me real examiner?

1 Yes Vital 26. Place of Death (Check only one) Hospital: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Division of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation completed filled in by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29d. Date signed (Month, Day, Year) D16428 30. Name and address of person who complet cause of death (Item 23a) (Type, Print) M.D. 300 West 9th St., Frederick, MD 21701 Casper Cline, 31. Date filed (Month, Day, Year) State Registrar

22

MCGNOUN

Physician

Known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bertha H. Maloney 05 19 2012 9:49 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22410 Slidell Road Montgomery Boyds 7. Age (In yrs. last birthday) lf Under 1 Yea **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours (Month, Day, Year) **Director** 219-18-2961 sual Residence of Dece 1 □ M 2 💢 F Yrs. 89 08/06/1922 Pennsylvania or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Howard Columbia 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 21044 U.S.A. <u> 5400 Vantage Pont Road - Apt.</u> ral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: Year or Dates White er than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) alth and Mental Hygien 27 is marked other to reaumatic event, the Medical Technologist 12 Δ Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Daniel C. Hall Mary E. Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 22410 Slidell Road - Boyds, Maryland Sandra A. Sloane (daughter) tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/22/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funera Home, P.A. 6 11750 Belair Road - Kingsville, Maryland 21087 CL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Esophagal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or in that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery been signed by tne aπer should be detached for Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home 2 **20**No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death <u>ن</u> 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Certifica Accident 1 Yes 2 No filled in by the Investigation 24 hours after death Funeral Director, ⊒ Accider ⊒ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the be Medical 29a. Certifier of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the b (Check Certifying Nurse Practitioner: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the within To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) o giv D47447 May 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris 6334 Cedar Lane - #103, Columbia, Maryland 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 3 2012 Registrar A pares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1353 PM Ronald William Miller Sr. Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** more Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 212-36-1350 1 □ XM 2 □ F 5-29-1941 **Director** 70 Yrs Usual Residence of Decedent show d Hygiene. Lother than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director VA Farmville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23901 USA 33 Thompson Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1

Yes 2 □ No 1 Yes If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filled wit Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. 12th Self Employed <u>Fintrepreneur</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Miller Mae White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Licy A. Miller/Wife 33 Thompson Road, Farmville, VA 23901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-25-2012 Baltimore, MD Metro Crematory Wylie Funeral Home P.A. of Baltimore Co. 22. Name and Address of Facility 21. Sign 0 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition as Reda adenacionoma with mediate cause) Approximate Interval Between Onset and Death Physician 3 months Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or do a consequence of, Cause (Disease or injury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed page 2 hours after death. neral Director; After this certificate I 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director; After this certifies funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 No Accident Suicide Investigation 6 Could not be

Division of Vital Records,

Registrar

State

filled in by the

Medical

4 Homicide

29a. Certifier

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hibba-tul-Rehman, 900 Caton Ave, Baltimore, MD,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 05/21/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month BEVERLY 2:30 P M FAIRALL MAXWELL 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16712 Goldsborough Avenue Prince George's Laurel 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months 1 🗆 M 2 🖫 F Days Hours Country)
Maryland Director 214-36-2822 80 931 Nov. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Maryland must be notified at 10d. Inside City Limits Director 1 Tes 2 v No MD Prince George's Laurel 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? with 23a Funeral 20707 16712 Goldsborough Avenue USA items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces Black, White, etc. o þ filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 → Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or other 2 James Albin Fairall Serena Amelia Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Brooks Maxwell, Jr/ Clermont Drive, Alexandria, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery 5/20/2012 Laurel, MD Stonature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician. Failure to Thrive months Medical Due to (or as a consequence of) Examiner Radiation Cystitis l year Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760 Ged certificate be executed burial-transit Radiation Colitis 20 years attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\mathbb{X} \) No Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, Completed Chronic Pain Syndrome 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Of the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 s. autopsy performed? Yes 2 No 2 X No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 X No Other: 4 Nursing Home 5 M Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) D13671 May 16, 2012 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) B.G. Manejwala 14201 Laurel Park Drive, Laurel, MD / MD 20707 32. Registrar's Signary State Registrar

12-03706 Travis Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Travis Miller	1-For State Pagistrar Certificate of Death Reg. No.	2 625
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Very	3. Time of Death 2335 hrs
	4a. Facility Name (if not institution, give street and number)4b. City, Town, or Location of Death4c. County of DeathEast Milton Avenue and East Chase StreetBaltimore	1
Funeral Director	122	
ow any	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 X Yes 2 No
the Maryland or 28a-f show iffied at once. Director	10e. Street and Number 1022 N. Luzern 108. Zip Code 21213 109. Citizen of What Cour	
death with or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	
nore, MD 21215-0036 segs 1 and 2 should be filed within 72 hours after nt of Fleath and Mental Hygeine. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by 1	Elementary/Secondary (0-12) College (1-4 or 5+) 2 College (1-4 or 5+) Food Service Hospitalit	
ID 21215-0036 : should be filed within 7 and Mental Hygiene. 77 is marked other than mitte event, the Medical To Be Comple	Leroy Miller Sr. Brenda Carter	202026-224-2
MD 21 d 2 should tht and Me n 27 is ma n 47 is ma	Brenda Carter 1022 N. Luzern Baltimore, MD 21213	
Baltimore, ME pernit. Pages I and 2 s Department of Health as Important: If item 27 injury or other fraum	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/26/2012 Dundalk, M.	D
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Phillip A Weatherford 2431 E Oliver Street Baltimore, MD 2	1213
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
	Sequentially list conditions, b	
60, the be executed hysician and e burial - transit Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-
e execute cian and rial - trans	d	
SOX 6871 leath certifice attending pl for use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month C 21c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23d. Date of delivery Month C	Day Year
P.O. E res that the d signed by the detached d by Phy	1 Yes 2 ✓ No 3 Prob	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly entification: To Be Completed by Peritification: To Be	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Ye	topsy findings available completion of cause of
Vital F ysician: nis certifi director,	25. Was case referred to medical examiner?	: Scene
ion of Vi tending Physi eath. or: After this the funeral dir		
Division o vite Hospital or Attending within 24 hours after death. To the Fuorral Director: Aft completely filled in by the fune edical Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined (Specify) Local Street 4 Homicide (Specify) Local Street	
To the Hos within 24 h To the Fuo completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	
H 3 H 2	29b. Signature and title of certifier 29c. License number O.C.M.E. May 15, 2012	nth, Day, Year)
31	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	te 31. Date (lied (Menthy Peux Year) 32. Registrar's Signature	

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month VERONIEA MILLEK MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Frederick Villa Nursing Home Catonsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 216-42-6955 66 **Director** 6/8/1945 1 M 2 X F Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? pe I Funeral 21229 USA 5163 Frederick Ave. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed al Hygiene. d other than "nature event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12 Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ith and Mental F 27 is marked or traumatic even ပ္ Magdeline Robert Michael McGinn Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health atem 27 i 5163 Frederick Ave., Baltimore, MD 21229 <u>Mark Miller</u> (Son) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plan Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery 5/21/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee. 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MYOCAKAIAL INFARETION ついいじて Medical Due to (or as a consequence of) **Examiner** HYPERUPIDEM. YCARS Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 1 Yes 2 g P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, DEMONTA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No _ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0075844 MAY 18, 2012 5411 OLD FREDERICK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA2 77.70 28 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IKESZAROS 2012 a Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner 14 MORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 92 Director 1 M 2 F 11-21-1919 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No IMMORE Edge nere 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces' Black, White, etc 2 No 9 Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify white If Yes, Give Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Hersh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bradley 22. Name and Address 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) been signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ate has b autopsy certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 \square Pending Natural within 24 hours after death. To the Funeral Director: Ai Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Pertitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

ALI Smmi 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

person who completed cause of death (Item 23a) (Type, Print)

730 6 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 6 Physician/ 10:30 A M MICHAELSON 2012 MARVYN Mai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital of Baltimore Baltimore Sinai N/A 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Country) 215-30-4826 1 🛛 M 2 🗆 F Director 11/16/1921 90 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 XNo RANDALLSTOWN MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 5 10e, Street and Number items 23a Funeral 21133 USA 3806 LUMO ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 0 1 XNever Married 2 Married Completed by 1 Yes 2 X No Specify "natural" 3 Widowed 4 Divorced WHITE Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me onee. Elementary/Secondary (0-12) College (1-4 or 5+) WESTINGHOUSE ELECTRONIC SPECIALIST Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MICHAELSON FRIEDA SKOI NATHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 DORSET HILL COURT, OWINGS MILLS, MD JUDITH M. HAMAN/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/20/2012 BALTIMORE, MD BETH TFILOH CONGR. 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Fun 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute ischemic Physician/ day s disease or condition resulting in death) Medical Due to (or as a consequence of) 6 day Examine My ocardi al Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for self-consequence of that initiated events signed by the attending physician and Due to (or as a consequence of): resulting in death) Last or Attending Physician: The law requires that the death certificate be exer by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute renal fathere, severe ischemic 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cardiomyo packy 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗡 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Certificate: 28d. Describe how injury occurred After 1 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29c. License number 29b. Signature and

State Registrar

2

D70334

May 16. 20/2

2401 W Belvedere Ave, Baltimore. MD

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lijun Zhow Sinai Hospital & Baltimore.

Please Type or Print in Black Inde ble Ink. Ensure All Copies Are Legible.

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Funeral Director		5. Social Security Number		6. Sex		•	last birthday) 35 Yrs	If Under Months		\Box	B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Foreign Country) MD					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Fur	neral Service	Licensee	/		2 3 &	Teph	ddress of Fa	rown	Jr.	June	eral H	ome	PA	
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Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: Completely filled in by the	<u> </u>	29a, Certifier 1 (Check only 2 V	Certifying Phy Medical Exam	iner:On the	the best of r basis of exa anner stated	amination ar	ge, death occurr nd/or investigation	ed at the tin on, in my op	ne, date and p pinion, death	place, and occurred at	due to the cau t the time, date	se(s) and pla	d manner as sta ce, and due to	ited. he cause(s)	
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		Laron Locke	MD. As				^{23a)} 900 W. Bal	timore S	treet, Balt	imore, M	1D 21223					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PRIVETTE Month **Physician** WILLIAM 4.10 RM 05 8 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SPRING FUTURECARE COLLY BALIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina **Funeral** Date of Birth (Month, Day, Year Months Days Hours Min. 1 M 2 □ F 214-50-6422 75 Director 11/21/36 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified Baltimore Maryland 1 √Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be rury or other traumatic event, the Medical Examiner must be rusy USA 2130 Walbrook Avenue 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. l □ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Specify: Black 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Woodholme Country Elementary/Secondary (0-12) College (1-4or 5+) Cook Club 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sennie Hinton Ed Pvivette ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27610 19a. Informant's Name/Relationship (Type. Print) 1229 Downing Rd.Raleigh North Carolina Carolyn Y.Privette 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/24/12 Dundalk, Maryland Trinity Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licensee Home 4210 Belair Road Baltimore, MD. 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pissase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditiens contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director; After thi completely filled in by the funeral is 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Tyes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 0 0 0 6 9 3 1 9 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address erson who completed cause of death (Item 23a) (Type, Print) Ra Pankallemp 21234

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 Phyllis Yvonne May 7:42 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Hospital E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours 02/20/1939 West Virginia Director 214-36-9348 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 724 Susquehanna Avenue 21903 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 | th and Mental Hygiene. ?**7 is marked** other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Healthcare injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Earl Ellis Wilson Glenice Beatric 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 30 Louise Court, Rising Sun, Janet Farmer / Daughter MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🗍 Cremation 3 🗎 Removal from State 4 X Donation 5 Other (Specify) 05/21/2012 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Funeral Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Signic Shock with MODS Physician/ disease or condition resulting in death) Medical a consequence of) Examiner (week Preumoma aspiration Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) Year Pregnant at time of death 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1, Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 5 Pending injury 1 Yes 2 No Accident Investigation after death Director: / 3 Suicide 6 Could not be within 24 hours after des To the Funeral Directon completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 11/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 05/17/2012 D66176 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINAY SHARMA, MO 106 BOW STREET ELKTON. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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12-03652 Charles Pindell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Balti permit. Departm Imports	10	Muly m. Cheles Name and Address Facility Franklin St Nancy m. Wallace F. S. Bacto	21239 md.
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Hospi 24 hou Funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the within To the comple	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	
		Theodox 100 Mind TR O.C.M.E. OGME May 13, 2012	<i>/</i>
1		30. Name and address of person who completed cause of death (Item 28a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
	ate	31 Data filed (Mark) Day Vend	
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hours after death Director: To the Funeral 7

Certification: 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined (Specify) Multi-Family Apt. 7925 Spice Berry Circle, Gaithersburg, MD 4 V Homicide 29a. Certifier 1 Certifying Physician: To the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 6, 2012 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State Registrar

6 m

QCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Yea MAY Physician/ 18, 12:35 P M PATEKA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 DOT AND 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours POLAND 88 220-52-3302 1 □ M 2 🛣 F Director Yrs 04/01/1924 ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State death with the Maryland Director 1 🗆 Yes 2 🖺 No BALTIMORE BALTIMORE MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 3421 BIRCH HOLLOW ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: WHITE If Yes. Give Completed 3

Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) GROCERY SELF EMPLOYED 8 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MALKA SEGAL **FEFER** JONAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 BIRCH HOLLOW ROAD BALTIMORE, MD 21208 MARLENE SZAPIRO / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUKAMUNO 05/20/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses 21208 8900 REISTERSTOWN ROAD PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition currance Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The lew requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the a detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Ves 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🕅 No Other: 4 Nursing Home 5 Residence မူ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Demi 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in a property of the proper Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 2012 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 16267

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 19, 2012 2110 hrs Anthoni **Medical Examiner** con 4c. County of Deatl 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Bon Secours Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign 114-88-623 Director 1 M 2 F Country) Usual Residence of Decedent 10d. Inside Çity Limits 10c. City, Town or Location 10a. State 10b. County 1 / Yes 2 No Howard 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7970 ones ō Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married Yes 2 1 No Black 1 Yes 2 No specify: If Yes, Give Year 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12 Finisher 18 Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle (Street and Number or Rural Route Number, City or Town, State, Zip Code) olumbia 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State National Donation \$ Other Specify 22. Name and Address of Facility Signature of Funeral Service Lice Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Wedical Death a Narcotic and Ethanol Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examinel if any, leading to immediate causa Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ing physician and as the burial - transit Physician/Medical AMENDED 23a,27,28a-f,per me,g927 5-30-12 sm X UNPENDED 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Month Year Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death for us 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) Tothe Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this ceriff 25. Was case referred to medical of Vital æ Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 27. Manner of Death 28b, Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Natural 1 Yes 2 X No unknown Division 5 Pending fd 8:37 pm the fd 5-19-12 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3000 Blk. Windsor Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined Baltimore, MD. Found in Auto Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number May 20, 2012 O.C.M.E. al 30. Name and addless of person who completed cause of death (Item 23a) COME Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) gatrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 18 Month 05 9:54 PM Physician/ Mary Lorraine Powell Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A gres 1more HOURITUA 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Min. 0872841934 1 □ M 2 🛣 Virginia 092-28-9139 Yrs Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State Director 1X Yes 2 ☐ No Baltimore N/AMD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 21229 Culver St. 218 N. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces þ 1 Never Married 2 Married 🗌 Yes 2 💢 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) 12th Grade College (1-4 or 5+) Self Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Geneva Malone Augustus Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,2\,4\,4$ 19a. Informant's Name/Relationship (Type, Print) 7203 Bogley Rd. Unit 303, Windsor Mill, MD Donna Wilkes(daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD National Cem. 05/23/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licens Si ature o 2140 N. Fulton Ave., Baltimore, 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final DAYS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine Due to (or as a conseque ir any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📈 No 1 Z Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 🗹 Natural 5 Pending Investigation Accident
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

MDHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mo

legistrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ 7:04Pm RADEL 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hay None tous Social Security Number 9. Birthplace (State or Foreign If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XXF Months Days Hours Min 11/13/1932 80 Pennsylvania 195-28-3871 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10h County 10c City Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 No Pennsylvania Lititz Lancaster 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral filed within 72 hours after death with al Hygiene. 17543 USA 340 East Main Street Page 1 and 2 should be filed within 72 hours after death vacent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, and the second and are second as a second and a second and a second and a second and a second and a second and a second a s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27. No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married XX Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Susan B Heisev Enos H Hoffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 East Main STreet Lititz, Pennsylvania 17543 William A Radell Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 kurial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. Brunnerville Meth.Cemetery : 05/23/2012 Warwick Twp, Pennsylvania Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Se nature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician/ 1551 We Intraventrialar disease or condition resulting in death) Medical Que to (or as a consequence of) Examiner hemorrhad Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir physician and the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No ျ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 27. Manner of Death e Hospital or Attending Pl 124 hours af er death. e Funeral Director. After th pleted filled ir by the funera 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled ir by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 8001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day, Year)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month /5 5 Physician/ 1924PM 30 LYNN 7012 AYCE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTMORE UNIU, MD MEDICAL CEUTEL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 11-19-2009 212-87-3766 Director 1 □ M 🎾 F 2 MD Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2 X No MD Baltimore Windsor Mill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 5 Liberty Place, Apt. 12 21244 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Caucasian If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) the 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kayla Jones Bryce Ritter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kayla Jones/Mother 5 Liberty Place, Apt. 12, Windsor Mill, MD 21244 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5-24-2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funt ral Symice Licen 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LETHAL ARRHYTHMIA 36 HOURS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 48 Hurs INCULATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 1 WEEK Exami certificate be executed Cause (Disease or injury that initiated events resulting in death) Last SUSPECTED SEPSIS and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Pregnant at time of death been signed by the a should be detached f Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYDRANGUCEPHALY RESPIRATORY FAILURE, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy completely filled in by the funeral director, page 2 performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 🗌 Yes 1 Dispatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 29b. Signature and title of certifier D69696 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALMERE. ST SUITE 104 GRERIE

Registrar

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30.5 M 2012 Medical Mal 4a. Facility Name (if not institution, give street and number, Examiner or Location of Death 4c. County of Death Hmor . Social Security Number Funeral If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. (Month, Day, Year) Hours Country Director 157-38-2547 1 □ M 2 🗓 F Oct. 24, 1954 New Jersey Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director ty Yes 2 □ No Prince George's Laurel 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 15441 Arbory Way 20707 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Laurel Board Administrative Coordinator 12th of Trade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Feldman Virginia Tallman 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Thomas Reinhardt, Jr. 15441 Arbory Way, Laurel, MD 20707 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) West Arundel Crem. 5/20/2012 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physiciani Metastatic disease or condition resulting in death) Aduno carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year this certificate has been signed by the raid director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ျ 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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2 3 2012

31. Date filed (Month, Day, Year)

SHARMA

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ 8:25 P M Robert Lester Rusteberg May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 159 Porter Drive Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 212-12-4716 **Director** 1 🛛 M 2 🗆 F November 18, 1920 Maryland 91 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director be notified 1 X Yes 2 □ No Annapolis Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral must I 21401 United States 159 Porter Drive should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Examiner Black, White, etc. 1 X Yes 2 □ No 1939-If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 1965 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the United States Navy Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Rusteberg Helen Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 159 Porter Drive, Annapolis, Maryland 21401 Teruko Rusteberg/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Maryland Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 24, 2012 Crownsville, Maryland 21. Signature of Funeral Septice Licens 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will El Doven M00672 23a. Part 1. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Physician/ en disease or condition resulting in death) Medical Due to (or as a consequence of Thrive **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy perform 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated DOSZ023 a showers

X

State Registrar who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 16, Physician/ 2012 11:40 A Marie Jacqueline Sylvain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care at North Point Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 121-54-2178 73 Director 1 🗆 M 2 🗰 July 18, 1938 Haiti 10b County 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland Director Examiner must be notified 28a-f Rockland Spring Valley 1 X Yes 2 No NY 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 10977 10 Hillman Place USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. **Black** "natural", Specify: Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumair. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Marie Marcelus Armand Sylvain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Hillman Place, Spring Valley, NY Marie G. Regis 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery crematory or other place, Brick Church 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-21-2012 Spring Valley, NY 4 ☐ Donation 5 ☐ Other (Specify) emeterv Capitol Funeral Services, Inc. Signatu of Funeral Service Licensee 22. Name and Address of Facility 7211 Lee Highway, Falls Church, VA Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 17~ Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine Эни в (слея е совящиваю об burial-transit Due to (or as a consequence of): resulting in death) Last iding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) atten Po in the past 12 months?
1 Yes 2 No Month Day Year signed by the at Id be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ disad Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 Yes Yes 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific. 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b, Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No 2 Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29b. Signature and title of certifier D69540 5/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 24 Parkville MD words Rd 8813 Walham State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5457 M Physician/ HOMAS MA 20 2012 DMITH Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Future Care - Cherrywood Reisterstown Baltimore 5. Social Security Numbe 213–14–2993 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 89 **Director** 1X M 2 F May 27 1922 MD Show 10d. Inside City Limits or 28a-f shov notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r items 23a or ner must be n Funeral 21136 US 12020 Reisterstown Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status "natural", or iter ledical Examiner Black, White, etc. ģ 1 Never Married 2 X Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: res, Give Year or Dates. 1943–45 Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) transmission mechanic self-employed 12 n and Mental Hygier is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Kay (Black) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Crawley Smith 6 Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Timothy Smith 5990 Farthest Out Drive, Sykesville, MD 21784 -son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State May 25 2012 Baltimore, MD Loudon Park Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road, Winfield, MD 21784 art . Enter the disease, or complications shork, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e on each line Ir me ate Cause (Final FAILURE TO Physician. Medical resulting in death) Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) for Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as nding ! IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death the t a Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed k should be det \$ 1 Yes 2 No 3 Probably 4 Unknown PHSUMONIA Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After work? 1 🗌 Yes 5 Pending injury 1 Natural 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie R088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUSANE #203 BALTIMONE MANY /AND 21209

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Yuri Simanin 19:30 20 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours Min Director 217-57-0952 1 🛛 M 2 🗆 F 53 3-31-1959 USSR show Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Montgomery North Potomac 28a-f 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11544 Paramus Drive 20878 United States ıral", or items 2 I Exa⊞iner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications Computer Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Igor Simanin Sara Vidershain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11544 Paramus Dr., North Potomac, Maryland 20878 Anna Simanin - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Judean Mem. Gardens | 5-22-2012 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Edward Sagel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final et and Death Physician/ AMCHONT! disease or condition MINTEN Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequent resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Year Month Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ 1 Yes 2 No Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 5/21/12

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

6420 Rock coops Dr #4100

completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	-	For State Registrar			and / De		nt of H	Health and I Death	-	/giene	012	1627
Physician Medica	ıl	Decedent's Name (First, Middle, Lois S. Sige1 As Facility Name (If not institution,		h orl					2. Date of Do Month 5	Day 13	Year 2012	3. Time of Death
Examine Funeral	1	Suburban Hospit	al		s. last birthd	Bet	hesd	If Under 24 Hrs.	8. Date of Bi	Мо	ty of Death ntgome 1 9. Birthp	ery lace (State or Foreign
Director		207-26-4996 Usual Residence of Decedent 1								ay, Year) -1933	Penr	nsylvania
death with the Maryland items 23a or 28a-f sho	Ulrecto	MD Montgo	mery		10g. Citizen o		Od. Inside City Limits 1 X Yes 2 No					
_ L.S	by runera	5555 Friendship 11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Deced	ces?	U.S.		0815 dent of Hi cify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	United		e S an Indian,
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygtene. Important: If item 27 is marked other than "natural", or my injury or other traumatic event, the Medical Examples. To Bo Committed by	Completed D	3 Widowed 4 □ Divorced 15. Decedent (Specify only highes)	If Yes, Give Year or Dat 's Education	es.	16a. De	1 Yes	al Occupa		dina	Specif	y Whi	te
rd 2121 led within 7 Hygiene. other than ent, the Me		Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	College (1-4	4 or 5+)	lite	a. DO NOT use	e retired)	Profres 18. Mother's Nam	ional		h Care	2
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iore, M ge 1 and 2 s tr of Health : If item 27 or other tra	-	Carin Sige1 - D 20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 4 □ Donation 5 □ Other (Sp		20t	. Place of Di	3 Snow sposition (Nar crematory or c	ne of	e)	Date	20c. Location	- City or Tov	vn, State
Baltim permit. Pac Departmen Important any injury		4 Donation 5 Other (Sp. 21. Signature of Funeral Service Lice				22. Name an	d Addres	ss of Facility	Danzan	sky-Go1	dberg	
- Physician/		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on eacl	h line.			e of dying					Approximate Interval Between
Medical Examiner	,	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (o Cardi	r as a conse omy op	equence of):							
0 0 s be executed sistian and e burial-transit		Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Records, P.O. Box 68760 The law requires that the death certificate be executed aste has been signed by the attending physician and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Exami	1 2	F FEMALE: 3b. Was decedent pregnant In the past 12 months? 1 Yes 2 No	у			ate of deliver	ch, Virginia g yland 20852 Approximate Interval Between Onset and Death very Day Year the cause of death? obably 4X Unknown opsy findings available ompletion of cause of					
4s, P.O. uires that the nisgned by the uld be detach		Part II. Other significant conditions	s contributing to dea	ath but not i	esulting in th	e underlying o	ause give	en in Part I.				
Vital Records visidan: The law requir is certificate has been s director, page 2 should		CAD							24a. Was autor perfo	osv	Were autops prior to com death?	pletion of cause of
f Vital Physician: this certific al director.	2	5. Was case referred to medical examiner? 1 Yes 2 X No 7. Manner of Death	Hospital: 1 💢 In 28a. Date of		ER/Outpa	tient 3 DC	Othor	4 Nursing Ho	k only one) ome 5 \square Resid	dence 6 Oth		
S page 8		1X Natural 5 Pending 2 Accident Investigat 6 Could no determine	(Month, tion t be 28e. Place of	Day, Year)	injur home, farm,		work?	? Yes 2□No		now injury occur Street and Numb vn, State)		Poute Number,
he Hospital in 24 hours and he Funeral I piletely filled	1	(Check 2 Medical Exa	hysician: To the bes iminer: On the basis urse Practitioner: T	of examinat	ion and/or inv	estigation, in r	ny opinior	n, death occurred at	the time, date a	nd place, and du	e to the caus	e(s) and manner stated.
To the within E comple	2	9b. Signature and title of certified	Ju6 - X	Zen	V2-	29c.	License			29d. Date signe		
12		D. Name and address of person wh Zenuz Sima Nour	ani - 860				Rd.,	Bethesd	a, Mary	land 20	814	
State Registrar		NAY 23	2012	usurar s Sigr	B. 4	faces						

			1 — For State Registrar 1. Decedent's Name (First, Middle, Las	State of Ma	aryland		irtmen tificate				Reg. I	20	12	1627
~~~	Physicia Medi	cal	Lawrence Howard	Stander						2. Date of D Month		1 ² 7 2	/ear	3. Time of Death 13:30 M
-	Exami	ner	4a. Facility Name (if not institution, give  Holy Cross Hospit						Location of De Spring	ath	4	4c. County of <b>Montg</b>		
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours Mi		ay, Year	)	9. Birthplac Country)	
	aryland a-f show fied at	ector	10a. State 10b. County  MD Montgon	ery	_	Town or Loc						I	10d.	Inside City Limits
	vith the Mi 23a or 28 st be noti	Funeral Director	10e. Street and Number 3142 Gracefield				10f. Zip	Code <b>904</b>			_	Citizen of Wh		?
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give		lf.	as Deced	ent of His ify Cuban	, Mexican, Pue	Specify Yes or No erto Rican, etc.)	-	Black,	American I White, etc.	
21215-0036	72 hours a "natural edical Ex	Completed by	3X Widowed 4 □ Divorced  15. Decedent's Et (Specify only highest gra	Year or Dates.		16a. Decede	ent's Usua	al Occupat k done du		orking	16b.	Specify: Kind of Busi		try
1212	d within lygiene. ther thar nt, the M	Be Con	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Contr	NOT use	r				Constr	uctio	n
Maryland	ld be file Mental H arked of atic ever	To B	17. Father's Name (First, Middle, Last)  Oscar Friedman							ame (First, Middle Zimmern		n Surname)		
Mar	d 2 shoul alth and I 27 is ma er trauma		19a. Informant's Name/Relationship (Ty  Vicki Understein	, , ,	er	_				Rural Route Numb				,
Baltimore,	age 1 an ent of He nt: If item y or othe	k i	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	cei	ace of Dispos metery, crema	ition (Nam atory or ot	ne of ther place,	)	Date	20c.	Location - C	ity or Town,	, State
Baltir	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Euneral Service Lines			<b>r</b> 22.	Name and	d Address	of Facility	20-2012 dward Sa ke, Rock	ige1	Funer	al Di	
	hysician/		23a. Part I. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	olications that caused ne cause on each line Congest		Do not enter	the mode	e of dying,					Ap	pproximate terval Between nset and Death
	Medical  By Medical  By Medical  By Medical  By Medical  By Medical  By Medical  By Medical  By Medical  By Medical	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Chronic b. Due to (or as a Due to (or as a	Kidn	ey Dis	ease	- St	tage 4				M	onths
Box 68760	ith certin ittending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic p Other (spe					23d. Date o	-	y Year
ds, P.O.	requires that the deal been signed by the a should be detached t	þ	Part II. Other significant conditions co	entributing to death bu	ut not resul	ting in the un	derlying c	ause give	n in Part I.					ause of death? ly 4 <b>X</b> Unknown
Division of Vital Records,	ine law rec ate has be- page 2 sho	Completed								24a. Was auto peri 1 \subseteq Yes	opsy ormed?	prio dea	re autopsy for to completth?	findings available etion of cause of
/ital	sician: The certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	205	D/O + - + - +	0 M B0	Other	ce of Death (Ch					
n of \	ding rnysician: :h. After this certific funeral director,	cate: To	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injur (Month, Day	у 2	R/Outpatient 8b. Time of injury		Bc. Injury a work?	at	Home 5 Res 28d. Describe			Specify)	
Divisio	no the nospital of Attend within 24 hours after death  To the Funeral Director. A completely filled in by the f	I Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc		ne, farm, stree			63 2 110	28f. Location City or To			or Rural Rou	ıte Number,
	ne nospi iin 24 hou he Funer ipletely fill	Medical	29a. Certifier (Check only one) 1 X Certifying Phys 2 Medical Examination only one) 3 Certifying Nurs	ician: To the best of r ner: On the basis of ex e Practitioner: To the	amination a	and/or investig	gation, in m	ny opinion.	, death occurre	d at the time, date	and place	ce, and due to	the cause(s	s) and manner stated
	vithin 2  To the I  comple		29b. Signature and title of certifier  Anne	Conan	MI	$\supset$		License r	number 7 Z8	4		ate signed (A		Year) 2012
			30. Name and address of person who co	ompleted cause of de	eath (Item 2	3a) (Type, Pri	d, Si	ilver	r Sprin	g, Maryl		.,		
H	Stat	te	31. Date filed (Month, Day, Year) NAY 2 3 2	32. registra	r's Signatur	1. 160	Mad	,						

DHMH 17 Rev 06-2011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State of	f Maryla					and N	1ental Hy	/gien	ie 🔾	010		07
			State Registrar				C	Certificat	te of L	Death			Reg. N	No. 2	012	16	21
	Physicia	n/	1. Decedent's Nam		_{.ast)} Silberste	-i						2. Date of Do Month	Ε	Day	Year	3. Time of	Death
-Ke	Medic Examin	_	4a. Facility Name (if					4h City	Town or	r Location	of Death	5	$\frac{1}{1}$	-	2012 y of Death	5:37	A ^{IVI}
	LAGITIII			ornden [		,			ethe		Or Doutin				gomer	v	
	Funeral		5. Social Security N		. Sex	7. Age (In yrs.	last birthda		r 1 Year		r 24 Hrs. Min.	8. Date of Bi				ace (State or	Foreign
188	Director		488-26- Usual Residence		1 🛛 M 2 □ F	86	Yrs		Jayo	1,00,0		1-3-			MO	<i>y)</i>	
and	show d at	or	10a. State	10b. County		10c. C	ity, Town o	r Location							10	d. Inside City	y Limits
Maryl	28a-f otifiec	Director	MD	Montgo	mery	Ве	thesd	a								1 🗶 Yes	2 🗌 No
the the	sa or	al D	10e. Street and Nur						p Code				10g. (	Citizen of	What Count	ry?	
ith wit	ms 20 must	Funeral		ornden 1		and Constant	0 1		817		1-1-0/0	-16 - 24			Stat		
<b>215-0036</b> in 72 hours after dea	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at one.	Completed by Fi	11. Marital Status  1  Never Marr 3  Widowed		12. Was Deced Armed Ford 1 X Yes If Yes, Give Year or Date	ces? 2  No <b>WW</b>	II	If Yes, spe	cify Cuba	n, Mexica	n, Puerto	cify Yes or No Rican, etc.)			ce - America ck, White, et		
15-(	"nat ledica	əldı	(Spe	15. Decedent's ecify only highest	Education grade completed)		(G	ecedent's Usu ive kind of wo	ork done d		st of worki	ng	16b.	Kind of B	lusiness/Indi	ustry	
212 within	iene. r thar the M	Con	Elementary/Seco	ondary (0-12)	College (1-4	4 or 5+)		e. DO NOT us ancial	,	nning	2		1	insur	ance		
DC v belied v	al Hyg I othe vent,		17. Father's Name (		,							e (First, Middle	_				
ylar Id be	Menta arkec atic e	2	Richard	Silbers	tein					Le	eonor	a Eise	nste	ein			
Maryland 2 should be filed	7 is m		19a. Informant's Na					_				l Route Numb	-				
<b>e</b> , <b>e</b>	Healtl tem 2	-	Erna S1		n - Wife	20h		4 Thor		Terr		Bethe			yland - City or Tow		
nor age 1	ent of nt: If if y or o		1 XBurial 2		Removal from S	State	cemetery, (	crematory or	other plac				1		•		,
Baltimore,	partmoortar portar / injur	ŀ	21. Signature of Fur				raen	of Rem				_2012 dward :	Sage	arks 1 Fu	neral	Maryl Direc	and tion
B B	an In De		16	-11	ape	Jane		1091 R	ockv:	ille		, Rock					
			23a. Part 1. Enter to shock, or hear	the disease, or co	emplications that ca one cause on eac	used the dea h line.	th. Do not	enter the mod	de of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betw	
	ysician/		Immediate Cause ( disease or conditio		_ Brain	Tumor										Onset and De	
	Medical kaminer		resulting in death)	•	Due to (o	r as a consec	uence of):										
12.114		ner	Sequentially list co- if any, leading to im	nmediate 💹	b. Due to (o	r as a consec	uence of):										
uted	d ansit	ami	cause. Enter Under Cause (Disease of that initiated events	II IJUI Y	C												
<b>60</b> te be executed	hysician and the burial-transit	dical Examiner	resulting in death) L	Last	Due to (o	r as a consec	quence of):										
	ohysic the bi	dica			d												
ision of Vital Records, P.O. Box 687. Attending Physician: The law requires that the death certifica	attending ph		F FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco									334 Da	ite of deliver		
Sox eath o	d for u	icial	in the past 12 r	months?	4 Pregna	irth 2 🗌 Fet ant at time of		3  Ectopic 5  Other (s		У							ear
D. E	by the	yh's	g 🗌 Unknown		g ∐ Unkno												
, P.O.			Part II. Other signifi Hydrocep		contributing to dea	ath but not re	sulting in th	ne underlying	cause giv	en in Part	1.					cause of dea	
rds equire	hould	eted														ıbly 4 🔀 U	
9C0	has je 2	Completed by	Dementia									24a. Was auto			Were autops prior to com death?	sy findings av pletion of car	ailable use of
Z E	certificate rector, pag		Diabetes  25. Was case referre		us				26 Pla	ace of Dea	ith (Check	1 Yes			1  Yes 2	□ No	
Vita yslcia	is cert direct	To Be	examiner?	No No	Hospital:	npatient 2 🗆	ER/Outpa	itient 3 D	Otho	er.		ne 5 <b>X</b> ] Resi	dence	6 □ Oth	er (Specify)		
of ng Ph	n. After this funeral d		27. Manner of Death 1   ✓ Natural	5 Pending	28a. Date of		28b. Time injur	e of	28c. Injury work	at		8d. Describe					
ion tendii	tor: A	Certificate:	2 Accident	Investigat	he			М	1 🗆 '	Yes 2	-						
Division of Vital Records, all or Attending Physician: The law requires	within 24 hours after death.  To the Funeral Director. After this certific. completely filled in by the funeral director,		4 Homicide	determine	28e. Place o	of Injury - At h	ome, farm,	street, factor	y, office		2	28f. Location ( City or Tov			er or Rural F	oute Numbe	r,
The Hospital	nours ineral ly filled	Medical	29a. Certifier 1	X Certifying Pl	nysician: To the bes	st of my know	/ledge, dea	th occurred a	t the time	, date and	place, an	d due to the c	ause(s)	and manr	ner as stated	1.	
The H	he Fu	Mec	(Check 2 only one) 3	☐ Medical Exa ☐ Certifying N	miner: On the basis urse Practitioner: 1	of examination  To the best of	on and/or in my knowled	vestigation, in dge, death occ	my opinio	n, death o ne time, da	ccurred at ite and pla	the time, date a ce, and due to	and plac the caus	e, and due se(s) and n	e to the caus nanner as sta	e(s) and manr ated.	ner stated.
	707	1	9b. Signature and	title of seftilier	ins			290	. License		F 7 1		29d. D	ate signe	d (Month, Da	ay, Year)	
•				1 000	1			i	ML	00026	5/1		5	Slic	115		
X		1	30. Name and addre		o čompleted cause D - 10605		, , , , ,		#500	). Ka	nein	oton M	arv	land	20805		
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	Registra	r		AY 232	012	was,	8. A	and									
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State of Maryland / Department of Health and Mental Hydiene O. 1. 0

			For State Registrar	State of Ma	aryland / Depa	artment of F tificate of E		i Mental Hy	giene 2	012	162/9
	Physicia	ın/	1. Decedent's Name (First, Middle					2. Date of De Month	eath Day	Y <b>e</b> ar	3. Time of Death
	Medic Examir	cal	Vanlila  4a. Facility Name (if not institution	Navnitla1	Shah	4b. City, Town, or	Location of Dea	May	18	2012 unty of Death	00:40A M
1	Exami		Holy Cross Hos	pital			er Spri			ontgon	
	Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	rs. 8. Date of Bir	rth		place (State or Foreign
	Director		218-13-5216 Usual Residence of Decedent	1 □ M 2 🙀 F	91 Yrs.	INOTATIO Dayo	Trodio Triii	(	21, 1920		nd <b>i</b> a
and	show	o.	10a. State 10b. County		10c. City, Town or Loc	cation					10d. Inside City Limits
Maryl	28a-f	Director	Maryland Montg	omerv	Si	lver Spri	ng				1 🗌 Yes 2 🙀 No
the 1	a or 2 be no	Ö	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?
th witl	ns 23 must	Funeral	14426 Bonifant			209				ited S	tates
r deal	or iter siner	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mari</li></ul>	12. Was Decedent Ev Armed Forces?	li li	Vas Decedent of His f Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White,	
<b>3</b> afte	ral", c Exan	q pa	3 🔀 Widowed 4 □ Divorced	If Voc Cive	1	☐ Yes 2x No	Specify:		Spec	cify: As:	ian Indian
5-0 2 hour	"natu dical	Completed	15. Deceder	nt's Education est grade completed)	16a. Deced	lent's Usual Occupa	ation	orking	16b. Kind o	of Business/Ir	ndustry
#in 72	than than ie Me	mo	Elementary/Secondary (0-12)	College (1-4 or 5+	·) life. D0	O NOT use retired)	uning most of w	Orking			
G Wit	Hygie other ent, th	Be C	17. Father's Name (First, Middle, L	ast)	Н Н	omemaker	19 Mothor's N	lame (First, Middle,	•	wn Hom	e
Be ⊞	ental rked o ic eve	욘	Chandulal Paril					en Parik		urie)	
Maryland 21215-0036  2 should be filed within 72 hours after death with the Maryland	and M s mai		19a. Informant's Name/Relationsh		19b. Mailin	g Address (Street a	_			n, State, Zip	Code)
e, M and 2 s	of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Vijay Shah/Son		14426	Bonifant	t Park 1	Place, Si	ilver S	Spring	, MD 20906
Baltimore, permit. Page 1 and	it of H : If itel or oth		20a. Method of Disposition  1  Burial 2  Cremation	3 Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place Arunde I	) Max	Date 7 19,	20c. Location	on - City or To	own, State
tim t. Pag	rtant:		4 Donation 5 Other (S	pecify)	Cr	ematory		)12			aryland
Ba E	Department of Important: If any injury or once.		21. Signature of Funeral S	me MO	$\begin{array}{c c} 22 \\ Dc \\ 14 \end{array}$	Name and Address naldson 11 Annapo	s of Facility Funeral olis Roa	Home & dad, Odeni	Cremato	ory. P arylan	d ^A 21113
			23a. Part . Enter the disease, or shock, or heart failure. List o	complications that caused t							Approximate Interval Between
4.0	ruician/	1	Immediate Cause Final disease or condition resulting in death)	aFailure	to Thrive	2				- 1	Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate	D	na B Cell					_	
rted .	d ansit	Examiner	Cause (Disease or injury that initiated events								
executed	ian an irial-tr	E	resulting in death) Last	Due to (or as a	consequence of):						
7 60 icate be	physician and s the burial-transit	edical	,	d						$\rightarrow$	
certifica	ding p		IF FEMALE:	23c. If <u>ye</u> s, outcome of	pregnancy						
<b>BOX</b> death of	been signed by the attending should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2	Fetal death 3	Ectopic pregnancy Other (specify)	/			Date of deliv Month	very Day Year
. he ရ	y the ached	hysi	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	g 🗌 Unknown							
that the	ned b e deta	by P	Part II. Other significant condition	ns contributing to death but	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use co	ontribute to th	he cause of death?
dS,	en sig ould b	ted	Basal Neoplas	m Primary		<u> </u>		. 1 🗆	Yes 2 🔀 No	3 Pro	bably 4 🗆 Unknown
	as be	Completed						24a. Was	psy	prior to co	opsy findings available ompletion of cause of
<b>9</b> = 1	certificate has t director, page 2 s							1 Yes	2 X No	death?	2 🗆 No
<b>ITa</b>	certifi	00	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:		Other	ce of Death (Ch				
DIVISION OT VITAI RECORDS, tal or Attending Physician: The law requires explanated that	eral di	6: To	27. Manner of Death	28a. Date of injury		28c. Injury	4 LJ Nursing	Home 5 Resid			0
nding	r: Afte	icat	1 X Natural 5 Pending 2 Accident Investig		Year) injury	work?	res 2 🗆 No	EGG. DEGGINGET	low injury occi	arred	
/ISIC	recto	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		/ - At home, farm, stre	et, factory, office				nber or Rurai	l Route Number,
	ral Di							City or Tow			
he Hosp in 24 ho	To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	(Check 2 Medical E	Physician: To the best of m xaminer: On the basis of exa Nurse Practitioner: To the b	mination and/or investi	gation, in my opinior	n, death occurred	d at the time, date a	and place, and	due to the car	use(s) and manner stated.
To th	To t		29b. Signature and title of certifier	20/		29c. License		1	29d. Date sign		
			10000	ORC		D32	332		May	18, 20	12
	10		30. Name and address of person v Suresh K. Gupta			,	uito oo	0 641***	r Cari-	na MD	20902
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's		avenue, S	ulle 22	o, silve.	PALTI	.rg, rid	20302
	Registra		MAY 2 3 2012		hald						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY 16^{Day} 2012 4:00 A M ROSE SCHWARTZMAN T.T NDA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ARDEN COURTS BALTIMORE If Linder 1 Year | If Linder 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 08/21/1937 Vrs Director 74 DC 216-34-5376 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Funeral 23a 8909 REISTERSTOWN ROAD 21208 USA r than "natural", or items the Medical Examiner mus within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify: Specify 3 K Widowed 4 □ Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) EDUCATION TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ NADISCH **GERTRUDE** GOLDSMITH SAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S item 27 SUSAN GORDON/DAUGHTER 3817 TIMBER VIEW WAY, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery crematory or other place! ARLINGTON CHIZUK AMUNO CEMETERY X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/20/2012 BALTIMORE, MD Signature of Funeral Service Lense 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ )ementic rears disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burial-Physician/Medical 68760 ast IF FEMALS use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 2 No 3 Probably 4 Unknown Records, 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was an autopsy performed? 2 No 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Tother Specify) 2 No within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dire 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Hospital or Attending **X** Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifie 29c. License number ٥ 00061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles St, Svite 4105 Touson MD 21204 32. Regis State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 | 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Smith Physician/ 8:15 2010 NOU a Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** H. mora The Johns Hookins HOSDITC 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min 218-46-9051 Director 1 XM 2 - F Yrs 11/15/1947 64 MD Usual Residence of Decede show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD n/a Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ttal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be i Funeral 5000 Denview Way Apartment E 21206 USA death ' Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, was becedent ever in 0.s. Armed Forces?

1 Yes 2 No
If Yes, Give 1966-72
Year or Dates. Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify. Speci**Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Factory Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even permit. Page 1 and 2 should be 1. Department of Health and Mental Important. If item 27 is meriany injury or other 1. ည Harris Gross Shirley Salone Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Smith/ Wife 1209 N. Ellwood Street Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Carrison Forest VA Cem 5.31.2012 Donation 5 Other (Specify) Owings Mills, MD Funeral Servi e 22 Name and Address of Facility John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore,MD 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertenside Antherosclerotic Cardio Vascular Disease Physician/ disease or condition resulting in death) Medical e to (or as a consequence of Examiner b. Narcotic Usaco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. မ 4 Nursing Home 5 Residence 6 Other (Specify) Funeral Director: After this stely filled in by the funeral 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 Yes 2 No 5 Pending death 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hours Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 18 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kuust ubha Puhl 1800 OHEANS St Baltimore Maryland 21287 te filed (Month, Day, Year) MAY 2 3 2012 State 32. Registra 's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 6:05A M Avis L. Shivers 201 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice
Social Security Number | 6. Sex Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours (Month, Day, Year) Country) Director 1 □ M 2 😡 F 217-66-5216 54 Vre Aug.20,1957 MD Usual Residence of Deceder item 27 is marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore 1 x Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 USA 1314 N. Chester Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Equity Management Property Manager permit. Page 1 and 2 should be filed Deportment of Health and Mentel Hyg Important: If Item 27 is marked other any injury or other traumant once. æ 18. Mother's Name *(First, Middle, Maiden Surname)* Vernell B. Langley 17. Father's Name (First, Middle, Last) ည Joseph C. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 6150 Marquette Rd. Balto, Md. Saidah Shivers (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 26,2012 Balto, Md Arbutus Mem.Pk Мау 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home
1412 F Preston St. Balto, Md. 21. Signature of Funeral Service Licenses Calvin B. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bread Physician/ auces Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) igned by the attending physiclen end be detached for use es the burlel-trensit **Hospital or Attending Physiclan**: The law requires that the death certificate be executed 24 hours efter death. Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes autopsy performed? 1 ☐ Yes 2 ☐ No in 24 hours ence.

the Funeral Director: After this commistely filled in by the funeral director, pa Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ nce 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) as MD d address of person who completed cause of death (Item 23a) (Type, Print) N Charles ABBAS 6701 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AM 0132 4a. Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Magional Medical Center NUMBERON Balhmore A Social Security If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 216-56-4327 Director 1 🗆 M 2 🔀 F 07/07/1949 Maryland 62 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 607 Stamford Rd. 21229 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: If Yes, Give Specify: Black 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry
Consumer Credit (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Payment Processor Clerk Counsel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Mary Madeline Blackwell Charles Haywood Stepney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Grovehill Rd., Baltimore, MD 21227 Yvette Owens(niece) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) on-site Crematory 05/18/12 Baltimore, MD Signature of Funeral Service Licenses Joseph Tr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 atrich N MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Pulmon Hrestension

Due to (or as monsequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical The law requires that the death certificate be as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 Unknown Unknown s been signed by the should be detach P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has filled in by the funeral director, page 2 performed 2 No Yes 2 No 1 Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ျှ I Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director; After 1 Natural (Month, Day, Year) 5 Pending М 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar 29b. Signature and title of certifier

Ame

31. Date filed (Month, Day, Year)

Maria

Starmon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland Department of Health and Mental Hygiene 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 00/2 ner era /Medical 4b City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A ursino mor Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** Months Days Hours Min. Maryland 60 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It. Marketal Exemination and the profilied at any Injury or other traumatic event, It. Marketal Exemination 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 res 2 No mDDirector N/A 10g. Citizen of What Country? 10e. Street and Number 115 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status □Yes 2X No 1 Never Married -2 Married Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Blac ģ 3 Widowed XX Divorced Completed 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public School Teacher years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth McCaskill Joseph Turner Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3912 Tiverton Rd., Randallstown, MD 21133 Wayne Turner(brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State on-site Crematory 5-/2-/2 Baltimore, MD 4 □ Donation 5 □ Other (Specify) රිප්ප්රිති නිට්ම් Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 of Funeral Service Licensee Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other signiff to conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2/11/0 this certificate 1 ☐Yes 2 No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 25391 5-10-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd, 21239 State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 20b, per fh, g927 5-23-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Thomison 33"nd 201 Levoy 02:19am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard olumbs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State of Foreign **Funeral** (Month, Day, 1 X M 2 □ F Months Days Hours Min. Country) Director 0 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10b. Count any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director olum bia MD 1 Yes, 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 21045 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 03/1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Midgle, Maiden Surname) I homison Jant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UNIMS Milk =mma Dat 5/29/12 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease Physician/ Coronary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ulmonare Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 5 Pending Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Pay, Year)

M219 23 40 2012 29c. License number 1050870 30. Name and address of person who completed cause of death (Item 23a) (Type Print)
SUZAN Abdo MD 10910 WHE Fallowed Parkway suite 202 (6 (mbc MI))
21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 3 2012 Registrar

FEMIN, SAMMER MAY19,2012 0007 Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physician Medical Examiner		23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	tailure. List only inal	y one cause on ea	ach line.	consequence	<u>.</u> ,	le mode o	of dying	, such as	cardiac or	res iratory an	rest,	<u> </u>		Approximate Interval Betw Onset and D	/een
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2012 1813 May 12, Herbert Edward Turnbaugh, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days Director 83 11/14/1928 Maryland 220-24-5099 Usual Residence of Decedent 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dupartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ary injury or other traumatic event, the Widgal Evan. Inc.: ust be notified at other. 10a. State 10b. County 1 ☐ Yes XXNo Funeral Director Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3527 Churchville Road 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 □Yes 2 No Specify. Specify: white Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Farmer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William E. Turnbaugh Martha M. Butler ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Turnbaugh (wife) <u>3527 Churchville Rd., Aberdeen, MD 21001</u> Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 05/23/2012 1 ☐ Burial 2 Cremation 3 ☐ Removal from State R.A.Ferris & Company | -5/18/2012 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee croter Aberdeen, Maryland 21001
r complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, ir complications that care ed the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEMORRHAGE INTRACRANIAL **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) signed by the attending physician Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Dav 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy performed?

1 □Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 🖊 Natural 1 □Yes 2 □No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a 1awc 10 Year) 31. Date filed (Month, Day, Registrar's Signature State MAY 2 3 201 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20Day 0628 AM thia May 2013 Medical cilit) Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimone Myltimore -11 MW3 1-105 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**F 219-56-8596 Hours Min. (Month Day Year 61 Director 06-13-Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director 28a-f BAUTIMORE 1 Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or dical Examiner must be Funeral 805 RICHWOOD AVENUE 21212 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. BWI AIRPORT College (1-4 or 5+) Elementary/Seconday (0-12) USTODIAN 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OWNSEND. ARRIETT DASHIELL 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOMEWOOD ST. APT 302, BALTO, MO 21218 SISTER SERINA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State BATTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Euneral Service I censee VAUGHN GREENE FUNGRAL SCUS 22. Name and Address of Facility 55 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 6 s Montrios Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year 5 Other (specify) Month Day Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director: After thi completed filled in by the funeral 27. Man of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

31. Date filed (Month, Day, Year)

3 2012

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1541 himone

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:00 P 2. Date of Death 20, Da2012 Year Physician/ Ma^{Month} George Earl Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bethesda **Examiner** 4c. County of Death Montgomery 5216 Westpath Way Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MI 8 Date of Birth **Funeral** Age (In vrs. last birthday) Days 1 XM 2 □ F 414-14-9671 92 (Month, Day, Year) 04/15/1920 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location Bethesda 10a. State 10b. County 10d. Inside City Limits Director MD Montgomery 1 Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a Funeral 20816 5216 Westpath Way 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. White 1 Never Married 2 Married Completed by 1 Tes 2 No Specify. Specify. 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry US Government (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mathmetician Be 18. Mother's Name (First, Middle, Maiden Surmame)
Mary Emma Johnson 17. Father's Name (First, Middle, Last) Charles Taylor 19a. Informant's Name/Relationship (Type, Print)
Nora Moser Taylor/Wife 19b Mailing Address (Street and Number of Bural Route Number (1914) 2781 State, Zip Code) and 2 short Health and tem 27 is r item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 225. Page 1 0 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Uniform Ser. Univ. Bethesda, MD injury or Important: If any injury or 4 ☑ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facili Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licensee MO1585 Rebec Alec 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 5 Other (specify) Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an Hospital or Attending Physician: The law autopsy certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural within 24 hours after death.

To the Funeral Director: After 5 Pending work?
1 Yes 2 No Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

0

29b. Signature and title

31. Date filed (Month, Day, Year)

NAY 2 3 2012

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type Print)
Brent Cole 5530 Wisconsin Ave. #700 Chevy Chase, MD 20815

29c. License number D60129

05 21, 2012

12-03715 Charles Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 16290

		1- For State Registrar	Certificate of	of Death	Reg. N	No.	
Physicia Iedical Exami		1. Decedent's Name (First, Middle, Last) Charles Raymond Taylo	r		2. Date of Death Month Da May 15, 2012	2	3. Time of Death 1008 hrs
4		Facility Name (if not institution, give street and number 1003 Leeds Avenue		4b. City, Town, or Location of Dea		4c. County of Death Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 7. As 217-98-7313 1 MM 2 F	ge (In yrs. last birthday)	If Under 1 Year If Under 24H  Months Days Hours M  rs.		MM/DD/YYYY) 9. Birti Foreigi 1982 Cou	
Maryland 28a-f show any d_at_ooce.	Director	MD 10b. County n/a  10c. Street and Number	10c. City, Town or Loc	Baltimore	10g. (	Citizen of What Coun	10d. Inside City Limits 1 Yes 2 No
rith the Maryland		1003 Leeds Avenue  11. Marital Status 12. Was Deceden	t Ever in IIS 13 \	21227  Was Decedent of Hispanic Origin? (	Specify Ves or No.	USA 14. Race - Americ	can Indian Black
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "oatural", or items 23s or 28s-f shematic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces 1 Yes 2 3 Widowed 4 Divorced If Yes Give Year or Pates:	? X No	f Yes, specify Cuban, Mexican, Puer Yes 2 No specify:	to Rican, etc.)	White, etc.	te
136 hin 72 hours ie. than "oatur edical Exami	ompleted t	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or 1 0	5+) during	lent's Usual Occupation (Give kind of most of working life. DO NOT use re		b. Kind of Business/Ir $n/a$	ndustry
D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than antic event, the Medical	Bec	17. Father's Name (First, Middle, Last) Gerald Joseph Taylor	Sr.	18.Mother's Nan Bonnie	ne (First, Middle, Maid Kay Gai	en Surname) ther	
and 2 should be fi tealth and Mental tem 27 is marked traumatic event,	욘	19a. Informant's Name/Relationship (Type, Print)  Angel Nowicki / Siste		ing Address (Street and Number or 3			
Baltimore, MC pernit. Pages I and 2 si Department of Health an Important: If item 27		20a. Method of Disposition  1 Removal from St  4 Donation 5 Other Specify:	20b. Place of Disponentate crematory or o	osition (Name of cemetery,	Date 20	c. Location - City or 1	Town, State
Baltir permit. I Departme Importation		21. Signature of Funeral Service License	22	Name and Address of Facility John L. Williams 1517 Park Heights	Funeral Di Ave Balti	irectors,	P.A.
Physician Wedical Examiner			am, Tramadol		or respiratory arrest, sodiazepine	shock, or heart	Approximate Interval Between Onset and Death
~ : 1134 P	Ļ	Sequentially list conditions, b					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
xecuted n and l - transit		d	27 28a-f 1	per me,g927 5-29-	-12 cm		
760, ficate be executed g physician and the burial - transi	Medical	IF FEMALE: 23c. If yes, outcome				23d. Date of delivery	
	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown	t time of death	Fetal death 3 Ectopic pregr Other (Specify)	nancy	Month Da	ay Year
i, P.O. E	<u>\$</u>	Part II. Other significant conditions contributing to deat	h but not resulting in the	e underlying cause given in Part I.		co use contribute to the	
of Vital Records, P.O. Box 68 is Physiciae: The law requires that the death certificate has been signed by the attending neral director, page 2 should be detached for use as	Completed				24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of S
ital liciao: s certifi rector,	B	25. Was case referred to medical examiner?	ent 2 ER/Outpatie	26.Place of Death (Check nt 3 DOA Other Nurs	only one)	idana 6 0thar	Seana
on of V nding Phys tth. r: After thi	tion: To	1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month, Day, No. 1) 27. Assistant Investigation fd 5-15	ury 28b. Time of	f Injury 28c. Injury at Work?	28d. Describe how i		Scene
Division of Vital  Hospital or Attending Physiciae: 24 hours after death.  Ruoeral Director: After this certif	Certification:	Z Accident investigation		reet, factory, office building, etc.	28f. Location (Stree or Town, State) Arbutus, M	t and Number or Rur 1003 Leed	al Route Number, City
the hin the	Medical (	29a. Certifier 1 Certifying Physician: To the best of mone) 2 Medical Examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of					
To with To con	Me	29b Signature and title of certifier	MOST	29c, License number O.C.M.E.		d. Date signed (Moni	th, Day, Year)
		30. Name and address of person who completed cause of or Victor Weedn MD JD Assistant Medica	,	W. Baltimore Street, Baltim	ore, MD 21223		
St Regist		31. Date filed (Month, Day, Year) 32. Regi (ra	ar's Signature	parl)			

OCME

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND PI LINE A-B, 27, 28A-F, PER ME G930 8/8/12 TRT

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month 19^{Day} Physician/ 2012 720 M Vaicekonis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Severna Park 642 Arleigh Road Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 173-26-6942 **Director** 1 □ M 2 🗶 F June 5, 1921 Lithuania 90 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Severna Park 1 Yes 2 X No Maryland Anne Arundel ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21146 United States 642 Arleigh Road death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 X Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event ***. (Specify only highest grade completed) (Give kind of work done during most of working Veterans life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Administration Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Pranas Latvys Marijona Baceviciute 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Miller Circle, Crownsville, Maryland 21032 Saulius Vaicekonis/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date West Arunde1 cther place) Crematory 1 Burial 2 X Cremation 3 Removal from State May 22, 2012 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Exames M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, on each line. **EXASNGUINATION** Approximate Onset and Death Immediate Cause (Final Pnysician/ reviose Revoli disease or condition resulting in death) Medical Examiner LEG INJURY Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Kes Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending FD 5/19/2012 UNK 1 Yes 2 XNo Investigation 6 Could not be SUBJECT TRIPPED NAD FELL filled in by the 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 642 ARLEIGH RD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined SEVERNA PARK, MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier reputy 0605 4 e and address of person who completed use of death (Item 23a) (Type, Print) ONZS 31. Date filed (Month, Day, Year) State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

auren Hollis Webster.	.auren	Hollis	Webster	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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-	~	9	-		140	Charles .	_	

		1- For State Registrar			Certific	ate of	Death					Reg. N	10.	UI	2 102	19
Physicia Medical Exami		Decedent's Name (First, Middle Lauren	ddle,Last) Hollis Webster								Date of D Month May 15,	Da	y Yea	ır	3. Time of Death 1418 hrs	
		4a. Facility Name (if not institution 13700 Baltimore Aver	n, give street and nur		ebste.		b. City, Tow Laurel	n, or Loca	ation of		may 10,		4c. County of		lo.	
Funeral		5. Social Security Number		7 Age (In	yrs. last birt	hday)	If Under 1	Vear I If	f Under	24Hrs.	8 Date of	Rirth/M			nplace (State or	
Director		227-51-7547	1 M 2XF	25	-	Yrs.			Hours	L Min	Dec.			Foreign		)C
any		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town	or Locatio	on .								10d. Inside City Lin	nits
. ₫	tor		ngton				100 71 0	<del></del> .							1 Yes 2	No
ith the Maryland 23a nr 28a-f shn notified at once	Director	10e. Street and Number 3520 S. Wakefi	eld Street	;			10f. Zip Co						Citizen of Wh	nat Coun	try?	
death with r items 23	Funera	11. Marital Status  1 X Never Married 2 Ma	12. Was Dece	dent Ever			Decedent of s, specify C					No-	14. Race White		an Indian, Black,	
after (	by F		orced If Yes, Give Year				Yes 2X						Specify:			
hours natur Exam		15. Decedent's Education (Spec			ed) 16a.		s Usual Occ st of working					16b	. Kind of Bu	siness/In	dustry	
5-0036 iled within 72 hou Hygiene. In ther than "nat	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+}	Eme	erger	су Ме	dica	1 T	echn	ician	. ]	Medica	a1		
21 be fil ntal F	Be	17. Father's Name (First, Middle, Ronald D. Webs									irst, Middle Lamp 1		en Surname)	)		
D 2'should and Me	ام	19a. Informant's Name/Relations					,						City or Tow		,	$\Box$
and 2 shou fealth and N	ŀ	Sharon Webster 20a. Method of Disposition	- Mother		20b. Place o						Arlı Date		on, VA			
Baltimore, Normit. Pages I and Department of Healt Important: If tiem	-	1 X Burial 2 Cremation		m State	cremate West	ory or othe		erv		5-18	-2012	P	ittsbu	ırgh	. PA	
Baltimo permit. Page Department o Important: injury or oth	ŀ	Department 5 Other Sp.  21. Signature of Funeral Service						•						_	Service	$\dashv$
E E G E O		shen b	and O	0									ia, VA		2310	
Physician /Medical		23a Part I. Enter the disease, or failure. List only one cause	on each line.				-				espiratory a	irrest, s	shock, or hea	art	Approximate Inter Between Onset a	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Chloroqu Due to (or as a c			olpi	dem Ir	toxi	icat	ion					Death	4
	9	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequer	oce of):							_				
*	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a c													_
ecuted and transit		events resulting in death) Last	d.	·	·											
ial a	ledical	X UNPENDED	AMENDED 2.	3a,27	7,28a-	f,pe	r me,g	3927	5-2	29–12	sm.					
	₹ k	IF FEMALE: 23b. Was decedent pregnant in th	e 23c. If yes, ou		pregnancy 2	Feta	l death	3 E	ctopic p	oregnanc	v	2	23d. Date of Month	delivery Da	y Year	
Box 68760, death certificate be attending physic of for use as the bur	Physician	past 12 months?  1 Yes 2 No 9 V Unk	4 Pregna	nt at time		=	er (Specify)									1
O. B at the dall by the		Part II. Other significant conditi			not resulting	in the un	derlying cau	se given	in Part	l.	23e. Did	tobacc	o use contril	bute to th	ne cause of death?	$\dashv$
s, P.O ires that t signed by	ğ										1 🗆 Y	es 2	No3 [	Proba	bly 4 🗹 Unknow	n
of Vital Records, P.O. I ag Physician: The law requires that the there this certificate has been signed by the meral director, page 2 should be detached.	pleted											opsy	р	rior to co	ppsy findings availal mpletion of cause o	
Rec The la icate h	Comp										1 Yes	formed?		eath? ✓ Yes	2 No	
ital Reician: The scertificate	a	25. Was case referred to medical examiner?	Hospital:		ED/O			Other		heck only		] p i	4	0 0 11 1	^	$\dashv$
of V g Phys ter thii eral di	입	1 Yes 2 No 27. Manner of Death	28a. Date of			tpatient ime of Inju		Injury at \					dence 6 🗸		Scene	$\dashv$
on cath.	ţi	1 Natural 5 Pend			fd	14:0	5 pm 1	Yes 2	2 <b>X</b> N	10 S1	ubjec	t to	ook me	dica	ations	
Division tal or Attendi rs after death. al Director:	Certification:	3 Suicide 6 Could	not be		At home, fa	rm, street,		ce buildin	ng, etc.	28	f. Location or Town,	(Street State)	13700	r or Rura	Route Number, C	ity
		29a Certifier	mined (Specify)  yslcian: To the best		te1/Mo wledge, dea		d at the time	e, date an	nd place	La	urel.	,MD.	•	_		
To the Hos within 24 h To the Fu	당		niner:On the basis of and manner sta		ion and/or in	vestigatio				ırred at th	e time, dat	e and p	olace, and du	e to the	cause(s)	
	2	29b. Signature and title of certifier	1000	,				ense num					I. Date signe ay 16, 20		h, Day, Year)	
	-	30. Name and address of person	who completed cause	of death	(Item 23a)			J.1¥1.∟.	•			1416				$\dashv$
		Carol Allan, MD Ass	sistant Medical E			V. Baltin	nore Stre	et, Ball	timore	e, MD 2	21223					
Sta Registi	-	31. Date filed (Month, Day, Year)		istrar's Sig	gnature	and.	,									$\neg$
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pau Month Physician/ Warne 2:30 AM 0/8 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Carroll Carrol -ospita Center Westminster 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex **Funeral** Hours (Month, Day, Year) 214 38 9348 Director 1**XX** M 2 □ F 71 June 26, 1940 Virginia Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location at 10a. State 10d. Inside City Limits death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 XNo MD Carroll Manchester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21157 4767 Wentz Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 K Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Finisher Be Department of Health and Mental H Important If flean 27 is marked out any injury or other traumation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rosella McPherson Paul E. Wyatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4767 Wentz Road Manchester, MD 21157 wife Margaret Wyatt 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Glen Haven Memorial Park May 18, 2012 Glen Burnie, Mi 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, MD 21225 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Entar the disease, or complications that co shock, or healt failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute COY disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit To the Hospital or Attending Physician: The law equires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Pregnant at time of death Month Day Yes 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diabetes mellitus, systemic inflammatory response 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an disea severe coronary arier page 2 s performed Yes 2 V of Anemia chránic inflammat 2  $\square$  No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 🗌 Yes 1 MInpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Boston M.C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, Maryland 21157 larroll Hospital Center State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wingate 12:45 AM May Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mercy Med 5. Social Security Number Medical Center Baltmore, If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) 1 M 2 D F **Director** 218 60 668 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director mD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Bolleville Ave 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ndary (0-12) College (1-4 or 5+) rinting Co. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname မ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other commentary 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) crematory or other place, 21. Signature of Funeral Service License 70 Fredhillon Pass Palte. MD 21229 23a. Part. Englithed sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Septicemia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown o. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires thin 24 hours after death.

the Funeral Director: After this certificate has been sign Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No completely filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 4 Nursing Home 5 Residence 6 Other (Specify) ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural iniury 2 Accident
3 Suice 5 Pending 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 1chize P256(8 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Saint Paul Place Baltimore 20215 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Watford Sr. 20 20^{Year}2 McKinley William 8:47p.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore Examiner 4b. City, Town, or Location of Death Towson Gilchirst Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) **Director** 239-48-4108 1 ☑ M 2 □ F 34 NC 08 04 77 Usual Residence of Decedent Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 H Yes 2 □ No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 739 North Grantley Street 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Black Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Lawn Care Self Employed 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marganer White should be file h and Mental F ၉ William Watford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Ryral Boute Number City of Town, State Time Cee), Md ge 1 and 2 sh nt of Health au : If item 27 Is Paula Watford-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State pernit. Page 1 a
Department of H
Important: If ite
any mjury or ot 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, King Memorial Park 5/26/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Signature of Funeral Service Licens tal 21215 Baltimore, 6 23a. Part 1. Enter the disease, or complication that caused shock, or heart failure. List only one cause on each line. at that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that the death certificete be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No ed by the a 9 Unknown P.O. is certificate has been signed i director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The lew requires in 24 hours after death. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate | Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wypu in 24 hours ane:

the Funeral Director: After this 

wately filled in by the funeral dir ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DW NOCKILL S ST 31. Date filed (Month. 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2: 45 AM James C. Winchester 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 058 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 4/1/39 Year) Days Hours Min. Virginia 1 🗷 M 2 🗆 F Director 214-38-2623 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 🖪 Yes 2 🗌 No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4905 Ridge Avenue 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 N Divorced Black Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Super Fresh Clerk / Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mary Winchester George Rucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele R. Williams / Daughter 4905 Ridge Ave. Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 5/29/12 Loudon Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 01 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure List only one cause on each line. r complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) day Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No signed by the atte Month Pregnant at time of death Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2**V**VN Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 1 ☐ Yes 2 🗷 No 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year, D 00

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0 . Age (In yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours 1 🖳 M 2 🗆 F Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. notified at Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number ò ms 23a or must be r ural", or items 2 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Newer Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify: 3 Widowed 4 Divorced "natural" Year or Dates. WW 11 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trai resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been signated by the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 autopsy 2 🖷 25. Was case referred to edica 26. Place of Death (Check only one) Certificate: To Be Other: 1 🗌 Yes 2 🗹 No 1 Inpatient 2 NER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28c. Injury at work?
1 Yes 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 No M Director: A od in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Directory

Completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29b. Signature and title of certifier 29d. Date signed (Month, use of death (Item 23a) (Type, Print) ho completed.

State Registrar (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Shamyah Willies

4a. Facility Name (If not institution, give street and number) 1644 03 05 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimac City

9. Birthplace (State or Foreign
Country)
71.D Mercy Medical (cutar Baltmar If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min 33 Months Days 1 □ M 2 🗹 F Hours 220-88-3414 05 Director 03,2012 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at agree. 1 ☐ Yes 2 ☑ No Director Baltimas Baltmare 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 104 Twin Willaw Court US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ to If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant 0 in-tant 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ဂ Antonio Willies Snantel, Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) owngs mills, MD Twin Willas Court Shantel Spence/meth 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State athedra 4 ☐ Donation 5 ☐ Other (Specify) - MSKTON 22. Name and Address of Facility 21. Signature of Funeral Service Dring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21222 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 hours promatunty /Medical ue to (or as a conseque of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 → No 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 272 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

the death certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physician: Hospital or

3altimore, Maryland 21215-0036

and attending physician for use as the buria sate has been signed by the atte page 2 should be detached for i certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital within 24 hours a To the Funeral C

2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

29a. Certifie

(Check only one)

Medical

State

Registrar

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

11 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Remya Arui

1689809

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAY & 3 2012 St.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 16299

		1- For State Registrar		(	Certific	ate of	Death		,	Re	eg. No.		
Physicia Medical Exami	ın/	Decedent's Name (First, Midd							2	2. Date of Deat Month April 24, 2	th	Year	3. Time of Death 1949 hrs
		Winston W 4a. Facility Name (if not institution		number)		41	. City, Town, o	or Location of	of Death	April 24, 2		ity of Death	
		1411 Nicolay Way					Essex				Baltim	ore Cou	unty
Funeral Director		5. Social Security Number	6. Sex	7. Age (In y		thday)	If Under 1 Ye Months Da		er 24Hrs. Min.			Foreig	thplace (State or
Director		223-96-5800	1X M 2	F	51	Yrs.	WOTHING DO	, iours		09/2	1/1960	) c _o	untry) VA
any		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town	or Location	า						10d. Inside City Limits
À		MD Balt	imore	Co.		Ess	ex						1 Yes 2 X No
Maryland 28a-f show 1 at once,	Director	10e. Street and Number					10f. Zip Code			10	0g. Citizen of	What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once,		1411 Nicola	y Way				212	21			U.S.Z	Α.	
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must he notified at once	uneral	11. Marital Status 1 X Never Married 2 M		Decedent Ever i	n U.S.		Decedent of H			cify Yes or No-		ace - Ameri hite, etc.	ican Indian, Black,
or deat	Fu		1 X Ye	s 2 N	lo				, r dono r				1-
irs afte	à	3 Widowed 4 Div 15. Decedent's Education (Spe	or Dates:		d) 16a.		es 2 X N		kind of wo	rk done	16b. Kind of	fy: Bla	
136 thin 72 hourse. re. than "nasedical Ex	Completed	Elementary/Secondary (0-12)		e (1-4 or 5+)			t of working lif						,
vithin ene.	티		_	ears		U	nempl	_			N/Z		
15-00 filed wind Hygier and other		17. Father's Name (First, Middle, Robert Wood								First, Middle, N y West		me)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	19a. Informant's Name/Relations			I 198	o. Mailing A	Address (Stre			ral Route Num		own State	Zin Code)
AD 2 shc 27 is imati		Eugene Woods		end)	7	1 Wo	rmley	Ln.,	, Lo	cust H	Hill,	VA :	23092
re, rand FHealt Fitem Fitem		20a. Method of Disposition  1 Burial 2 X Cremation	2 Pamaya				on (Name of c				-	Town, State	
Baltimore, permit. Pages I a Department of He Important: If ite		4 Quantion 5 Other S		II IIOIII State	on-s	íte	Crema	tory	5-1	11-12	Balt:	imore	e, MD
Baltimo permit. Pag Department Important: injury or ot	Ī	21. Signature of Funeral Service				j ² dS	e and Addre	ss of Egcilio	bwn_	Jr. Fu	ınera	l Hor	ne PA , MD 21217
Physician	$\dashv$	23a Part I. Enter the disease, or	complications the	t caused the de	ath Do no								Approximate Interval
/Medical	ļ	failure. List only one cause	on each line.					g, 50011 05 or	ardiac or r	copilatory arre	ost, shock, or	ricart	Between Onset and Death
xaminer	1	Immediate <b>(</b> ause (Final disease or condition resulting in death)		lerotic Card s a consequent		iai Disea	156						
	_	Sequentially list conditions,	b						_				
	nin	if any, leading to immediate raise. Enter Underlying Couse (Disease or injury that initiated	C.	s a consequenc	e or):								
asit ed	Examiner	events resulting in death) Last		s a consequenc	ce of):								
execu un and ul - tra		UNPENDED	d	D				- v					
760, ficate be g physicia the burit	/Medical	IF FEMALE:	27-5-	s, outcome of p	regnancy						23d. Date	of delivery	,
687 ertific ding p	jan/	23b. Was decedent pregnant in the past 12 months?			. 2	Feta	death 3	Ectopic	pregnanc	У	Month		Day Year
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Physician	1 Yes 2 No 9 Unk	noun He	egnant at time o ath known	' 5	Othe	r (Specify)						
O. Bat the		Part II. Other significant conditi	ons contributing	to death but n	ot resulting	in the und	derlying cause	given in Pa	ırt I.	23e. Did to	bacco use co	ntribute to	the cause of death?
ires that the signed by t	d by	Sarcoidosis; History	of Testicular (	Cancer, NO	S					1 Yes	2 No	3 Prob	pably 4 🗸 Unknown
ords w requi	Set									24a. Was a autops			topsy findings available completion of cause of
Reco The law cate has	Completed									perform	med? 2 ✔ No	death?	es 2 No
tal Recition: The certificate ector, page	Be	25. Was case referred to medical examiner?	Hospital:					e of Death (				=1	
Physical dir	၂၅	1 ✓ Yes 2 No 27. Manner of Death		Inpatient 2		utpatient		Other ₄		Home 5 18d. Describe h	Residence 6		: Scene
Division of Vital Records, rate or Attending Physician: The law requirers after death.  at Director: After this certificate has been sited in by the funeral director, page 2 should be		1 V Natural 5 Pend	(Mo	nth, Day,Year)	200.	i iii io Oi ii ije	·	Yes 2		od. Describe II	low injury occ	arrea	
ivision or Attence after death Director:	ertification		tigation 28e. P	ace of Injury - A	At home, fa	rm, street,	factory, office	building, etc	c. 2	8f. Location (S	treet and Nur	nber or Ru	ral Route Number, City
Divi	( ) L	4 Homicide deter	mined (Speci	fy)					ļ	or Town, St	tate)		
Divis  To the Hospital or A within 24 hours after completely filled in b			ysician: To the t					-					
To the within To the comp	Medical	2 Medical Example 29b. Signature and title of certifie	niner: On the bas and manne		n and/or ir			n, death occ se number	curred at t	ne time, date a			
•	-	OMAS S	1				i	.M.E.			May 9, 2	- •	nth, Day, Year)
	1	30. Name and address of person	who completed o	ause of death (I	tem 23a)						, 0, 2		
	3		istant Medica	•	,	/. Baltim	ore Street	, Baltimoi	re, MD	21223			
Sta	-		32.	gistrar's Sign	nature	7	. 50						
Registr		MAY 23	2012 🟒	www.	1. 1	par				-			
DHMH 17 Rev 1/200 OCME 2006	JI				OR	IGINAL					0	CME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ YUSUFOV 2012 OT.GA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner B21 timore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** BAKU AZERBAIJAN Hours 1 🗆 M 2 🗓 F (Month Day Year) 44 212-37-9749 68 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral USA 21208 3507 ENGLEMEADE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Force 1 ☐ Never Married 2 🔀 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) MEDICINE DOCTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ RAKHAMINOV RAKHAMINOVA MALKA MIKHAIL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3507 ENGLEMEADE ROAD, BALTIMORE, MD 21208 ZAVALU YUSUFOV/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other J.IBERTY PARK C SHAARET ZTON 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 05/21/2012 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Fulleral Service Licensee MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, Approximate Interval Between Onget and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Matasthe disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has performed? Yes 2 No 2 No 1 Yes this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 X No 1 Yes 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Dea 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending after death.

Director: Aff
in by the fur 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the l within 2 To the l Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and ti D0063298 2012

State Registrar

3

f person who completed cause of death (Item 23a) (Type. Print)

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last Physician/ 2141 ONALD BRAHAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Inpatient Care Center Harwood 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number If Under 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min (Month, Day 1 🛛 M 2 🗆 F Months 579-70-2774 16, 1953 Florence, NC 58 Yrs November Director Usual Residence of Decedent 28a-f show the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 No Bowie Maryland Prince George's 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral within 72 hours after death with USA 20716 15006 Nutcracker Place items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White, etc. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: **Black** 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Real Estate College (1-4 or 5+) Elementary/Seconday (0-12) other traumatic event, the Realtor / Insurance Salesman 2+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o ည Annie Bea Davis McDonald Abraham, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luann Abraham / Wife 15006 Nutcracker Place, Bowie, MD 20716 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Clinton, Maryland Resurrection Cemetery: 5/11/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line MONTH Immediate Cause (Final Physician/ MYCOSIS disease or condition resulting in death) FUNGOIDES Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) transit The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 1F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day Yes detached Unknown g Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Yes 2 No 2 No certificate 1 Yes Division of Vital 25. Was case referred to medical CAFT To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be ANDRIN (Specify) examiner? Hospital: Other: 2 No ARE CIR 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA |은 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 1 / Natural 5 Pending М Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 ature and title of cert

Registrar

DHMH 17 Rev 7/2009

e and address of

44T DEFENSE

son who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ May 2012 9:35 A M 8 Bernice Joyce Accetta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert 125 Allnutt Court 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. New Jersey 1 🗆 M 2 😿 F Months 03^{Menth}O³/1³9¹27 85 137-20-7046 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a, State Director Examiner must be notified 28a-f 1 Yes 2 XNo Maryland Calvert Prince Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Funeral 23a United States 20678 125 Allnutt Court items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of health and Mental Hyghen. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examilianty or other traumatic event, the Medical Examiliants. ☐ Yes . . 2 X No If Yes, Give Year or Dates. 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Mfg. Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sadye Feinberg Robert Dodds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4540 FIsh Hawk Ct., Chesapeake Beach, Maryland 20732 Joyce Eileen Roseto / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Immaculate Conception 05/10/2012 Hardyston Twp., NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, M01206 4405 Broomes Island Rd., Port Republic, MD 20676 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Ventricular Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of, that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 **X**No 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mitral Valve Replacement 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown nas Be 2

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death.

Director: Aff
d in by the fur 24 hours

Certificate:

Medical

29b. Signature and title

the Maryland

with

death

Baltimore, Maryland 21215-0036

Aortic	Stenosis			24a. Was an autopsy performed? 1 \(\sum \text{ Yes}  2 \) \(\frac{\frac{1}{3}}{3}\) No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No					
25. Was case referred to medical			26. Place of Death (Chec	ck only one)						
examiner? 1  Yes 2  No	Hospital:	spital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)								
27. Manner of Death  1   ↑ Natural 5   Pending 2   Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred					
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			28f. Location (Street and City or Town, State)	l Number or Rural Route Number,						
(Check 2 Medical Exar	nysician: To the best of my know miner: On the basis of examination urse Practioner: To the best of m	n and/or investigation, ir	my opinion, death occurred	at the time, date and place,	and due to the cause(s) and manner state					

29c. License numbe

D51949

29d. Date signed (Month, Day, Year) 05/08/2012

aRW State

person who empleted cause of death (Item 23a) (Type, Print) 30. Name and address

David Callatin 110 Hospital Road, Prince Frederick, Maryland 20678

Registr

MI

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

IIIC Austili Allei			artment of Health and Mental F Tificate of Death		201	2   630
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Deat     Month	eg. No. h Day Year	3. Time of Death
Medical Exami	ner	Eric Austin Allen		May 9, 20	12	1621 hrs
		Facility Name (if not institution, give street and number)     Atlantic General Hospital	4b. City, Town, or Location of Dear	th	4c. County of Death Worcester	1
Funeral		Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday) If Under 1 Year If Under 24Hi	s. 8. Date of Birt	th(MM/DD/YYYY) 9. Bir	thplace (State or
Director		214-11-4884 1⊠M 2□F 26	Yrs. Months Days Hours Mi	Sept 5	, 1985 Foreig	on PuntryMaryLand
ROY		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location			10d. Inside City Limits
	L	MD Howard	Dayton			1 Yes 2 X No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
the Natified		14159 Triadelphia Mill Road	21036		United Sta	+
th with	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U. Armed Forces?				ican Indian, Black,
er deal	F	3 Widowed 4 Divorced If Yes, Give Year		o Moan, etc.)	V.70-	nite
ırs aftı tural" pmine	ğ	15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind of	work done	Specify: WI 16b. Kind of Business/I	
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re		100.14.74 01 240.11000.1	, idada y
orthin ene.	E	3	Student		Collec	re
15-C		17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, M	faiden Surname)	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Montal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic evect, the Medical Examiner must be notified at once	To Be	Richard A. Allen  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	e Wert	her City or Town State	Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be fited within 72 hours Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natur iojury or other traumatic evect, the Medical Exam		Richard A. Allen/father	14159 Triadelphia Mi			ryland21036
Fe I and Fiteen		20a. Method of Disposition 20b. F	Place of Disposition (Name of cemetery, rematory or other place)	Date	20c. Location - City or	Town, State
Pages nent of		4 Donation 5 Other Specify: Arde	ent Cremation Syc 5/	11/2012	Hanover	Marvland
Baltimore, permit. Pages I an Department of He (important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hal	ry H. W	itzke's Fam	ilv FH Inc.
		23a. Part I. Enter the disease, or complications that caused the death.	14112 Old Columbia	Pike El	licott City	MD 21043
Physician /M	5 5	failure. List only one cause on each line.		or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Blunt  Due to (or as a consequence of				Death
	J	Sequentially list conditions, b				
	m in	if any, leading to immediate  Due to (or as a consequence of  Course Entar Underlying Course  C.	):			
od sit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	):			
50, te be executed sysician and burial - transit		d.  X UNPENDED AMENDED 23a.27.2	8a-f,per me,g928 6-8-1	2 cm		
ox 68760, ant certificate be ex- attending physician for use as the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregr			22d Date of deliver	<u> </u>
687 ertifica ding pl	<u>a</u>	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery  Month D	Day Year
eath or	75 1	1 Yes 2 No 9 Unknown Pregnant at time of dea	ath 5 Other (Specify)		1.	
Trhe de ached f	Physic	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tot	bacco use contribute to	the cause of death?
res tha	d b		10.4	1 Yes	2 ✓ No 3 Prob	ably 4 Unknown
rds v requi	ete			24a. Was a		topsy findings available ompletion of cause of
RecC The lay ate has	Completed			perform	med? death?	
tal Recian: The	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check			
Physic rathis ral dire	2	1 Yes 2 No No Inpatient 2			Residence 6 Other	:
odiog Pt. th. : After t		1 Natural 5 Pending (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	1	owinjury occurred jumped fro	om halcony
r Atter dear	ficat	2 Accident Investigation 1d 5-9-12	me, farm, street, factory, office building, etc.			-
Div pital or ours afte ceral Diu	Certification:	4 Homicide determined (Specify)	ote1	or Town, St Ocean C	treet and Number or Ru ate) 1701 Atla ity,MD.	intic Ave.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuceral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 2 W Medical Examiner: On the basis of examination are and manner stated.	ne, death occurred at the time, date and place, and od/or investigation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as state and place, and due to the	ed. e cause(s)
	Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mon	oth, Day, Year)
,	-	30. Name and address of person who completed cause of death (Item				
3	ate	Russell Alexander MD. Assistant Medical Exam  31. Date filed (Moran Pau Year) 32. Registrar's Signatur		nore, MD 212	23	
Regist	rar	MAT 11 2012 Lenus	B. Sparked			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 16304 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Trotter Boone Medical May 2012 12:14 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year **Funeral** . Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 212-34-9613 Months Days **Director** 1 M 2XX F 87 Yrs Nov. 4, 1924 Maryland Usual Residence of Decede 23a or 28a-f show 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 983 Lanna Way 21401 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★★No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: White **¾X** Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Frank Trotter Maude O'Malley and 2 should b Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Donald DeyErmand/son 47 Rockwell Court Annapolis, Maryland If item 27 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Augustine's Cem. Important injury 4 Donation 5 Other (Specify) 5/10/2012 Elkridge, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home any in once. oad 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death GI Bleed Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Crohn's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death igned by the at be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy 2 🗆 No Yes 2 X No 1 Tes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2XXNo Other: မ 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at i or Attending F after death. 28d. Describe how injury occurred **XX**Natural 5 Pending injury work' Division ☐ Accident ☐ Suicide Investigation М 1 Tyes 2 No Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 1 XX certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of cent 29c. License number 29d. Date signed (Month, Day, Year) D73348 May 4, 2012

State Registrar

31. Date filed (Month, Day, Year) MAY 07 2012

and address of person who completed ca

Madhavi Davuluri

2001 Medical Parkway

of death (Item 23a) (Type, Print)

Annapolis, Maryland 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie 12423 Chalford Lane Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number . Age (In yrs. last birthday) **Funeral** (Month, Day, Year, Days Months Hours Min. 93 1î M 2 □ F **Director** 406-16-4187 Yrs 1919 Kentucky 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10a. State with the Maryland Director Examiner must be notified 1 X Yes 2 No MD Prince George's Bowie 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or Completed by Funeral USA 20715 12423 Chalford Lane or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Navy 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Chemist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anne Powers 2 Wallace S. Brammell, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12423 Chalford Lane, Bowie, MD 20715 Pauline R. Brammell/Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery | 5/18/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility | Peall Funeral Home Signature of Funeral Service Licenses Bowie, MD 20715 6512 NW Crain Hwy., or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Hart 1. Enter the disease shock, or heart failure. Approximate 23a. Part 1. Enter Interval Between duse on each line eath Peath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury detached for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last to the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 4 Pregnant Pregnant at time of death 2 No 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 / Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one) To the 29d. Date signed License number

State Registrar

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of death (Item 23a) (Type, Print)

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# permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Funeral Director

	1	State Registrar  1. Decedent's Name (First, Middle,	Last)	•	` Cei	tificat	e of D	eath		2. Date of Deatl	eg. No. 2	0   2   6 3 3. Time of Death
ian/ lical	L	Helen V. Bury								May 1,	2012	Year 4:15 a
iner		la. Facility Name (if not institution, Prince George † s		•			Town, or heve:	Locatio <i>n</i> of r1v	Death			y of Death nce George's
al			6. Sex	7. Age (In yrs. I	ast birthday)	If Unde		If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day,		Birthplace (State or Fore Country)
r		214-30-1561 Usual Residence of Decedent	1 □ M 2 □ <b>X</b> F	7	8 Yrs.		,.			Jun. 9,		Virginia
Director	1	MD 10b. County Prince	e George's		y, Town or Lo		pper	Mar1	boro			10d. Inside City Lim 1   ✓ Yes 2   ✓
Funeral Di		Oe. Street and Number	on Court	'		10f. Zip	Code 207	74		1	_	What Country?
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Be Co	-	11			N	urse'	s Ai					althcare
To B	1	17. Father's Name (First, Middle, La Harry B. Harr	•							(First, Middle, M Kelley	aiden Surnam	ne)
	-	19a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street a			Route Number,	City or Town,	State, Zip Code)
		Stephen A Savoy	Jr./nep			-		on Ct	., U			, MD 20774
	2	20a. Method of Disposition  Burial 2 Cremation		State C	Place of Dispo emetery, crer	natory or c	ther place	9) 5	/7/2			- City or Town, State
ō	-	4 Donation 5 Other (Sp. 1. Signature of Funeral Service Li		) Me	tro Cr					1 Funer		more, MD
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dical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a consequ								
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Medical Certificate		only one) 3 Certifying	Nurse Practitioner:	To the best of r	ii) iliio iliouge							
			Nurse Practitioner:			- 1 1	License	^	2 ~			ed (Month, Day, Year)
	2	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practitioner:	NOING 1	Physicia	n d	License OO	^	35.	3   ²⁵		

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State of Maryland / Department of Health and Mental Hygiene For

		-	<ul> <li>State</li> <li>Registrar</li> </ul>						Cer	tifica	te of E	Death			Reg. N	lo.			
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	Funeral		5. Social Security No		6. Sex		7. Age (In			If Und	er 1 Year	If Unde	r 24 Hrs	8. Date of B	irth		9. Birtl	hplace (State o	or Foreign
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and 2	be filed w ental Hygi <b>ked othe</b> <b>c event,</b>	a)	17. Father's Name (			ems								e (First, Middle Le Hal					
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Morily Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Donation	☐ Cremation	3 ☐ Rei	moval fror		20b. Plac cem Beth	e of Dispo etery, crei	osition (Na matory or <b>Meth</b>	ame of other place • Cen	:e)		Date 7, 201				Town, State	)
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Division of Vital Records,	I or Atter after dea Director	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be	28e. Plac build	e of Injury	- At home Specify)	e, farm, st	reet, facto	ory, office			28f. Location City or To			er or Rui	ral Route Num	ber,
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month. Physician/ Christophine 1430 Burazer 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center Olney Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Min Hours 214-48-9922 **Director** 1 □ M 2**X** F 72 Dec. 17, 1939 Maryland or 28a-f show filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5309 Norbeck Road 20853 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify I Hygiene. other than "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked o ၉ Christopher William Burazer Virginia Hust 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Coyne/Attorney 400 University Blvd. West, Silver Spring, MD 20901 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State permit. Page Department c Important: If any injury or once. injury or May 8, 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery Silver Spring, MD 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 mont Pregnant at time of death Unknown 9 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Pr actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who c

John

BID

18111 Prince Philip Drive, Olney, MD

20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ а м Margaret Phyllis Breen 2012 3:15 Mav 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clarksville Howard Yolanda's Home Assisted Living If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 84 Director 171-22-6681 1 M 2 X F 1927 15, PA ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location death with the Maryland Director 1 ☐ Yes 2 🖾 No Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12103 Dalewood Drive 20902 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates1951-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after the fleath and Mental Hygiene. Item 27 is marked other then "natural", or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Librarian Montgomery County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Zauner Phillip Walter Margaret H. Gillmor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Veronica Breen/Daughter 3819 Gateway Terrace, Burtonsville, MD 20866 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 May 8 2012 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multi-Infarct Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 20 yrs Diabetes, Type II Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burian and attending physician and dior use as the buriactans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Pregnant at time of death Other (specify) 1 ☐ Yes 2<del>12</del> 9 ☐ Unknown q | | Ilnknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ĀNo 1 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural 5 Pending injury work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 4, 2012 D53966

State Registrar

DHMH 17 Rev 06-2011

5018

Dorsey Hall Drive, Ellicott City, MD 21042

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Kristin M. Clark, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 5/6 /2012 2:45 PM JAN-AKE GOTTHARD BLANCK Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 803 COXSWAIN WAY UNIT #108 ANNAPOLIS ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Director 564-90-4506 1 🛛 M 2 🗆 F Yrs. 7/20/1937 **SWEDEN** 74 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MARYLAND | ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 803 COXSWAIN WAY UNIT #108 21401 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced WHITE the Medical Decedent's Usual Occupation Decedent's Education Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) TUNNEL & MINE t of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION 12 5+ CIVIL ENGINEER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ AKE BLANCK GUNVOR HALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIV M. BLANCK/WIFE 803 COXSWAIN WAY UNIT #108 ANNAPOLIS, MD 21401 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date HESAPEAKE CREMATION ENTER 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State permit. Page Department or Important: If i any injury or ò 5/8/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS Signature of Funeral Service License HELFENBEIN & NEWNAM CREMATION 814 BESTGATE ROAD ANNAPOLIS. & FUNERAL CARE 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9800x disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. tor or activity Cause (Disease or injury ner Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy ate has been signed by the atter page 2 should be detached for to in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Tes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 2 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify, After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending I hours at er death, uneral Director Aft ely filled in by the fur Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certific M. J. Call Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number and the cause of the course of the c (Ch ock 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signa

who completed cause of death (Item 23a) (Type, P

Registrar's Signature

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Suite 210 Agrapaly Ma ZIHOI

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Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a-f show amportant in items 25a or 28a	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorce	Armed 1 7	Forces?			f Yes, spe	cify Cuba	ispanic Or in, Mexica Specify	an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Black, Specify:	White,	
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Baltimore, bermit. Page 1 and bepartment of Hea mportant, if item any injury or other		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Othe	on 3 🗌 Removal fr	om State	, ce	ace of Dispo metery, crei lantic	natory or	other plac	ry .	5/8/2			Location - C n Burr	-	wn, State Maryland
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6		that initiated events resulting in death) Last	Due Due	to (or as	a conseque	ence of):									
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Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2 Medica only one) 3 Certify	ing Nurse Practitio	basis of	examination	and/or inves	tigation, ir	my opini	on, death o	occurred at th	ne time, date a	and plac	ce, and due t	o the ca	use(s) and manner stated.
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CHS		30. Name and address of person			death (Item R人 いひ	23a) (Type,		50:7	E 11	00 A	KUIN	POL	-15,	ni	21401
State Registrar		31. Date filed (Month, Day, Year MAY	8 2012	2. Registr	rar's Signati	d. A	bar	1						7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 May 6 Hipolita M. Bernal 9:55 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Harmony Hall If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 214 76 4081 1 □ M 2 😾 F 88 08/13/1923 Panama Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Ellicott City Howard 1 Yes 2 X No 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 4654 Smokey Wreath Way 21042 Panama items ; 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force or Black White etc. ģ 1 Never Married 2 Married 2 X No 1

✓ Yes 2 □ No Specify: Panamanian Maryland 21215-0036 Yes If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Hispanic Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Own Home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, S . Page 1 and 2 st trient of Health a tant: If item 27 is 4654 Smokey Wreath Way Ellicott City, MD 21042 Karla M. Tropea/Daughter item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of P
Important: If it
any injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crest Lawn Mem. Gard 5-12-2012 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitHarry H. Witzke's Family FH Inc. Them allins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
Days Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Left Foot Ostromyelitis Months-Year Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease On Hemodialysis 1 ☐ Yes 2 📉No 3 ☐ Probably 4 ☐ Unknown page 2 should Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performe Coronary Artery Disease 1 🗆 Yes 2 🗔 No Yes 2 X No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🛣 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA lvq. 4 Nursing Home 5 Residence 6 Nother (Specify) asstd. 27, Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After (Month, Day, Year) 1 X Natural 5 Pending work? Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ag D0069962 5/7/2012

DHMH 17 Rev 06-2011

State

Registrar

6334 Cedar Lane Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fatima Ali Naqvi
31. Date filed (Month, Day, Year)

MAY 08

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Hezekiah Anthony Briscoe 03 2012 May 17:41P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 213 40 7609 1 M 2 D F 70 09/04/1941 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Temple Hills 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2427 St. Clair Drive 20748 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Station Superintendent Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Frank Briscoe, Jr. Mary Pauline Dobbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Briscoe/ Son 2427 St. Clair Dr. Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 5/10/2012 Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityBriscoe-Tonic Funeral Home embelle usca 10mi 2294 Old Washington Rd.Waldorf, MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Acute Atheroscienine Cardiovascular diseas disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if ary, leading to immedicause. Enter Underlying Due to (or as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYDEVTENSIM 1 Yes 2 No 3 Probably Yunknown YUSTITE CANCEL 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No Yes 2 No

26. Place of Death (Check only one)

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician/ Medical Examiner

that the death certificate be P.O. Box 68760

Division of Vital Records,

Important: I any injury o

Physician/

Medical

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

**Director** 

show

28a-f must be notified

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23a

items

Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m

Baltimore, Maryland 21215-0036

with the Maryland

Exami Physician/Medical þ Completed Be မ

25. Was case referred to medical

2 No

5 Pending

Investigation

6 Could not be

examiner?

27. Manner of Death

1 V Natural

3 Suicide 4 Homicide

29a. Certifier

Accident

31. Date filed (Month, Day,

and burial-tra attending physician as the ase ŏ detached has certificate funeral Certificate: the

Physician: within 24 hours after death.

To the Funeral Director: After this or Attending filled in by Hospital

Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) 150689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHILK MAHATAN MD. Auspital ( en) en 7503 Shratts Rd Clintonno 20735

28a. Date of injury (Month, Day, Year)

1 ☐ Inpatient 2 → R/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

State Registrar

ack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Lynde1 A M 0. Bowers 8:18 Apri1 24 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours Min 1/19/24 579-70-4963 88 **Director** Yrs Jamaica 28a-f shov aţ 10a. State 10c. City. Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No MD Prince George's Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 1416 Ray Road 20782 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 00 1 Never Married 2 X Married þ 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Jamaican Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working If Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Accountant Private Banking traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Page 1 and 2 should be Charles Augustus Hilda Plano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 Ray Road Hyattsville, MD 20782 Eriel A. Bowers (Spouse) f Health other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5 Department of Important: If any injury or once. Fort Lincoln Crematory 4/30/12 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Funeral Service Licensee nya 3401 Bladensburg 20722 Road Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Phy i jan/ disease or condition resulting in death) Sepsis Days Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection Davs Sequentially list conditions. Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): tran and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician a stached for use as the burial-Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death should be detached 1 L Yes Z L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Atrial Fibrillation, Diabetes Mellitus Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? Yes 2XXNo 1 Yes 2 No I or Attending Physician: after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ျ 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28a. Date of injury 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After (Month, Day, Year) iniury 5 Pending 1**★**XNatural 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined City or Town, State) Hospital Medical

Registrar DHMH 17 Rev 06-2011

State

completely

29a. Certifier

(Check

only one) 29b. Sigrial

Suresh K.

Date filed (Month,

3

ure and title of certifier

Gupta,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MD 9801 Georgia Ave. Ste. 220 Silver Spring, MD 20902

29c. License number

D-32332

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month. Day, Year) 04/24/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death April 28^{ay} Physician/ 2012 ear 5:18 Boito A MMario Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Annapolitan Assisted Living Community Annapolis If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Dean, PA Months 2 /97 T.929 83 723-18-3577 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director MD Anne Arundel Annapolis 28a-f ty Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be n Funeral 21409 84 North Old Mill Bottom Road United States items ; be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 🔀 Yes 2 🗆 No 1959-Black, White, etc Ь ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8 Automotive Industry Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Boito Pettibone Anthony Teresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Cheaspeake Beach, MD 20732 <u>Ronald R. Boito ( son</u> 3647 <u>Brookside Dr.</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 5/4/2012 Brentwood, MD permit. 21. Signature of Funeral pervice Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Kuta 3401 Bladensburg Rd Brentwood, MD 20722 nompas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ menti de disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the all d be detached fo 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has t lirector, page 2 s performed Yes 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify) 2 🗌 No ျှ 1 XYes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work?
1 Yes 2 No Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie. R143194 Name and address of person who completed cause of death (Item 23a) (Type, Print) gital Dr. # Gr Linthicum, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

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State Registrar iled (Month, Day

Box 68760

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Records,

of Vital

Division

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year DOROTHY ARN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Hours **Director** 579-20-5958 1 □ M 2 🖾 F 88 Yrs. Usual Residence of Decedent 6. Virginia Nov. 28a-f show 10b. County 10d. Inside City Limits death with the Maryland 10c. City, Town or Location Director 1 X Yes 2 No Prince George's Maryland Upper Marlboro ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3011 Geaton Drive 20774 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Black, White, etc. Armed Forces Completed by "natural", or Page 1 and 2 should be filed within 72 hours after ament of Health and Mental Hydiene. Part if then 27 is marked other than "natural", or unty or other traumatic event, the Medical Examitury or other traumatic event, the Medical Examitury. 1 Never Married 2 Married 2 🛂 No Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 X No Specify: Specify: Black If Yes Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Childcare Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Faggie Glover Maria Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lesa Davis - Granddaughter 20774 Department of Health Important: If item 27 any injury or other to once. 3011 Geaton Drive Upper Marlboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Heritage Cemetery 2012 Waldorf, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year signed by the a 1 ☐ Yes ∠ 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Hospital or Attending Physician; The this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature 29d. Date signed (Month, Day, Year) my ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year,

Projection Section (Project Committee)			-	_					k. Ensure			Legible	€.	
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Figure 1 Services Stronger   Services   Serv	•		1. Decedent's Name (First, Floyd C.	Middle, Last) Banks								20 ^{Year}	3. T 2 1	Time of Death 1:37Рм
The control of percentage   The country			4a. Facility Name (if not insi St. Thoma:	titution, give stre S More	et and number) Nursir	ng Ho	me	4b. City, Town, o	r Location of Death attsvil	le	4c.	County of De	ath G	
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shock, or heart failure. List only one cause on each line.  Medical Examiner    Medical Examiner	permit. Departn Imports any inju		5/.	B. Hus	of cc	373	22	Name and Addre	ss of Facility Hinedy St	unt Fui N.W.	nera Was	I Hom h, D.	e C. 2	0011
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Devore 6510 Kenilworth Ave  31. Date filed (Month, Day, Year)  32. Registar's Signature	iires that th signed by Id be deta		Part II. Other significant c	enditions contri	outing to death b	out not resul	ting in the u	ınderlying cause gi	ven in Part I.					
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Paul Devore 6510 Kenilworth Ave  State 31. Date filed (Month, Day, Year) 32. Registar's Signature	To t		29b. Signature and title of	pertifier	ZW=					1	29d. Date	1		ear)
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Russell Clifton Clay, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Western Maryland Health Systems Cumberland **Allegany** If Under 1 Year If Under 2 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) **Director** 235-54-8367 76 07/23/1935 West Virginia show at 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director must be notified 28a-f WV Mineral New Creek 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 30 Willow Court, Healy Heights 26743 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces Black, White, etc. Or 1 1 Never Married 2 Married Yes 2X No Yes, Give þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify "natural", Specify: Completed 3 Divorced 4 Divorced **Black** Year or Dates Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Heavy Equipment Operator Paper Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Clay Laura Ruth Price Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 30 Willow Court, Healy Heights, New Creek, WV 2674B Suellen Clay/ Wife item 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Keyser, WV Memorial Gardens 05/18/12 21. Signature of Funeral Service Licen 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street, Keyser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final .Ph sician/ SEPTIC DA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or i that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be P.O. Box 68760 the as attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 2 No been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown RENAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has baral director, page 2 % autopsy performed? 2 No 2 N completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No injury 5 Pending Investigation Accident □ Accider
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 To the P 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year)

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State 31. Date filed (Month, Day Year) 32. Registrate 32. Registrate 32. Registrate 33. Date filed (Month, Day Year) 32. Registrate 33. Date filed (Month, Day Year) 32. Registrate 33. Date filed (Month, Day Year) 32. Registrate 33. Date filed (Month, Day Year) 33. Date filed (Month, Day Year) 33. Date filed (Month, Day Year) 33. Date filed (Month, Day Year) 33. Date filed (Month, Day Year) 33. Date filed (Month, Day Year) 33. Date filed (Month, Day Year) 33. Date filed (Month, Day Year) 34. Date filed (Month, Day Year) 34. Date filed (Month, Day Year) 35. Date filed (Month, Day Year) 36. Date filed (Month, Day Year) 36. Date filed (Month, Day Year) 36. Date filed (Month, Day Year) 37. Date filed (Month, Day Year) 38. Date filed (Month, Day Year) 39. 
Robustiano Barrera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 Glenn Street Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16320 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Michael Scott Cheesman Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner nemoria aston ita 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ial Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Hours 214-88-7584 Director 48 1 🗓 M 2 🗆 F Sept. 21,1963 Maryland Yrs Usual Residence of Deceden 10d. Inside City Limits "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location njury or other traumatic event, the Medical Examiner must be notified at death with the Maryland Director MD Dorchester Cambridge 1 🗓 Yes 2 🗆 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Willowmere Lane 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 x No Specify: white If Yes, Give Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Detention Center lieutenant Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any pictant: or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Otto B. Cheesman III Donna Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 1006 Willowmere Lane, Cambridge, MD Sylvia G. Cheesman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State East New Market Cem. 5/9/12 East New Market, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. ture of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Marco Physician. MONTH disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 10 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 South Wash w. morte

State Registrar 31. Date filed (Month, Day, Year)

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #21 Per FH G927 5/23/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 2⁶012 12:35 p^M Evelyn E. Clayton Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery Fox Chase Rehab&Nursing Silver Spring Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Hours Min Country) Bluefield 1924 **Director** 235-38-0054 87 Yrs. 1 🔀 M 2 🗆 F West Virginia Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County notified at Director MD 1

✓ Yes 2 □ No Hyattsville Prince Georges 10e. Street and Number 10f. Zip Code r items 23a or ner must be n ò 10g. Citizen of What Country? Funeral 6060 Sargent Road Apt. 201 20782 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 hours after Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Federal Government <u>UnKnown</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transcorrect. မ James Evans Nellie Couch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 Golden Morning Dr. Mitchellville MD 20721 Dawn McCreary/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  $\stackrel{\mbox{\scriptsize M}}{\mbox{\scriptsize Burial}}$  2  $\stackrel{\mbox{\scriptsize C}}{\mbox{\scriptsize Cremation}}$  3  $\stackrel{\mbox{\scriptsize C}}{\mbox{\scriptsize Removal from State}}$ Baltimore National 5-7-2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home Juan D. Smith M01592 per DVR 3005 12th Street NE Washington DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. i.i.n Ischemic Cardia Arrhythmia Minutes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Years Sequentially list conditions, It on, It immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine Due to for as a consequence of executed burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 nding physics IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown jo Pregnant at time of death Month Day Year signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Breast Cancer Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus II page 2 s autopsy performed? Failure To Thrive 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 1 🔠 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Afted in by the fur 2 Accident
3 Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined filled in I within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of e 29c. License number 29d. Date signed (Month, Day, Year) 5-4-2012 R169951 30. Name and address of person who completed cause of death (Item 233 (Type, Print) John Hudson-Odoi 15245 Shady Grove Road Rockville MD, 20850

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year) **MAY 0 8201**2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marie Estelle Compton 6:20 Рм May 6. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) 218-38-5333 Director 1 🗆 M 2 🔀 F 71 June 26, 1940 Takoma Park, MD Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits must be notified at Director 1 X Yes 2 No 28a-f Prince George's Clinton Maryland ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20735 8707 Dangerfield Road USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify: White Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+ Compton Watch Repair Hygiene. Administrative Assistant 11 alth and Mental Hygie 27 is marked other in traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Edward John O'Brien Marie Steinour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vestal Compton / Husband 8707 Dangerfield Road, Clinton, MD 20735 t of Health other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5 Department of Important: If any injury or 5/11/2012 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final NGESTIVE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury -transit PERTENSION the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last ng physician ar as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse ( 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ate has been signed by the atter page 2 should be detached for u in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy s after death. al Director: After this certificate he led in by the funeral director, page performed' 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ဂ္ 1 X Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) 24 hours a

State Registrar

Medical

29a. Certifier

29b. Sign

(Check

only one)

ture and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

73.25A HAMONE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4652

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #9 Per FR G928 6/05/2012 Jh

Department of Health and Mental Hydiene

			For State Registrar	State of Marylan		artment of I tificate of I			giene _{Reg. No.} 🤈	012	16323
	Physicia		Decedent's Name (First, Middle, Last)     PAULINE SYNG GADE					2. Date of De 05/02/		Year	3. Time of Death 10:00 A M
~	Medie Examir		4a. Facility Name (if not institution, give single 13003 Camellia Dr.	·		4b. City, Town, o	r Location of Death	h		unty of Death	
	Funeral Director		5. Social Security Number 6. Sex 426-44-0028		ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 10/02/	l	9. Birth	nplace (State or Foreign ntry) Mississippi
	and show dat	tor	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Loc	cation					10d. Inside City Limits
	Maryl 28a-f notifie	Director	MD Montgamer	y Silv	er Spr						1X Yes 2 □ No
	with the s 23a or ust be	Funeral [	10e. Street and Number  13003 Camellia Dr	rive		10f. Zip Code 20906			10g. Citizen USA	of What Cou	intry?
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of F Yes, specify Cub:	lispanic Origin? (Sp an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, ecify: Bla	, etc.
15-0	72 hour "natu edical	plet	15. Decedent's Edu (Specify only highest grad		(Give A	ent's Usual Occup ind of work done	during most of wor	rking	16b. Kind o	of Business Ir	ndustry
212	within /giene.		Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired)	pervisor	•	Nat'l	Secur	ity Agency
Baltimore, Maryland 21215-0036	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  John L. Gadberry					me (First, Middle,		ame)	
lary	should be file and Mental   is marked c		19a. Informant's Name/Relationship (Typ	e, Print)	1	-	and Number or Ru	ral Route Numbe	r, City or Tow		,
e, Z	and 2 s Health tem 27		Debra Liverpool/d				a Drive,				
mor	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, crem	sition (Name of patory or other place) In Cem.	^{ce)} 05/1	Date .0/2012		ion - City or T ${ m wood}$ ,	
Balti	permit. Page 1 Department of Important: If it any injury or o		21. Signature Funeral Service Licenses	Rhoma			ss of Facility Sn				20850
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the deat						, III 2	Approximate Interval Between
	Ph _{sician/} Medical		Immediate Cause (Final disease or condition resulting in death)			- 1	Onset and Death				
	Examiner	يا	Sequentially list conditions,	Due to (or as a consequ	acrice oi).						
	arted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	Due to (or as a consequ	uence of):						
	cate be executed physician and sthe burial-transitions.	al Ex	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):						
3760	ficate b g physias the b	<b>ledical</b>	d	l							
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affare death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tractic.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No g ☐ Unknown	Bc. If yes, outcome of pregna 1  Live Birth 2 Feta 4  Pregnant at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	ру		23d.	. Date of deliv Month	very Day Year
ds, P.O	requires that the dea been signed by the should be detached t	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.				the cause of death?
Recol	<b>sician:</b> The law re certificate has be irector, page 2 sh	Completed						24a. Was autop perfo 1 🗆 Yes	rmed?	4b. Were auto prior to co death? 1  Yes	opsy findings available ompletion of cause of 2 No
/ital	ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒No	ospital:	EB/Outpotion	Oth	ace of Death (Chec			0.1. (0	. ,
n of \	<b>ling Ph</b> y n. After this funeral c		27. Manner of Death 1   X Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	y at </th <th>lome 5 Resident 28d. Describe h</th> <th></th> <th></th> <th><u>y)</u></th>	lome 5 Resident 28d. Describe h			<u>y)</u>
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Yes 2 □ No	28f. Location (S City or Tow		mber or Rura	al Route Number,			
_	e Hospit 124 hour e Funera leted fille	Medical	(Check 2   Medical Examine	cian: To the best of my knowler: On the basis of examination  Practioner: To the best of my	n and/or investi	gation, in my opinio	on, death occurred a	at the time, date a	nd place, and	I due to the ca	ause(s) and manner stated.
		2	29b. Signature and title of certifier  Amed 4. Acclaiment		, is to wiedge, a	29c. License	e number		29d. Date sig	gned (Month,	
	12				102a) (Fire - 5		v 5373		5/4/20	012	
			30. Name and address of person who cor Bernard A. Heckman	M.D., 8830 C	Cameron		lver Spr	ing, MD	20910		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture her	W.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5. Day 2012 ar Robert Joseph 10:35 Physician/ Marth Cole Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care Rockville Montgomerv Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) If Under **Funeral** Country) MA 1 X M 2 🗆 F Hours Au(Month, 1Pay, 19931 80 **Director** 579-36-2046 Usual Residence of Decede 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shore Examiner must be notified at Director MD 1 🗆 Yes 2 🔀 No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7405 Miller Fall Road 20855 USA death v 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Even III Argued Forces?

1 Yes Korrean
If Yes, Give Year or Dates Conflict Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 nan "natural", Medical Exar 1 Tes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Mechanical Designer event, Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ Robert James Cole Alice Gertrude Siddons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Cole/Wife 7405 Miller Fall Road, Rockville, MD 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 9 20c. Location - City or Town, State May 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2012 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility Cole Funeral Service 4110 Aspen Hill Rd., 21. Signature of Funeral Service Lig ces_{#1}80^A. MD 20853 Rockville. 23a. Part 1. Enter the disease, shock, or heart failure. List polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Immediate Cause (Final 10 vrs Dilated Cardiomyopathy Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Mellitus, Type II unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine Chronic Kidney Disease 10 yrs tran and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Atrial Fibrillation 5 yrs that the death certificate be P.O. Box 68760 as attending IE EEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No the Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ş pe Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No Yes 2X N 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 X No 1 Yes ER/Outpatient 3 DOA မြ 1 Inpatient 2 I 4 X Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b, Time of 28d. Describe how injury occurred Certificate: the Hospital or Attending 1X Natural 5 Pending 1 Yes 2 No death. Accident Investigation the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 (Check Certifying Nurse Practioner: To the hest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple only one 29b. Signaturé and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD22846 May 7, 2012

DHMH 17 Rev 7/2009

State

Registrar

15215 Shady Grove Road, Suite 306, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELLA

Robert DiBianco, MD

31. Date filed (Mo.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY Day Physician/  $\underline{\mathbf{A}}^\mathsf{M}$ COOK 2012 11:21 WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5265 WEST BONTWOOD TURN PG CLINTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Hours Min 577-72-6008 58 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDPG CLINTON 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5265 WEST BONIWOOD TURN 20735 IIS 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ρ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH METRO_MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM CORUN RENNA COOK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENNA C. SUMMERS/MOTHER 900 G STREET, NE, WASHINGTON, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8,2012 cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State MAY 4 Donation 5 Other (Specify) RIVERDALE PARK CREMATORY RIVERDALE, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signature of Funeral Service Licen. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ULM WAR disease or condition resulting in death) GNTRICULAR Sequentially list conditions if any, reading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year þ Completed Certificate: To Be

**Examiner** ding physician are as the burialcertificate be Box 68760 nse P.O. Division of Vital Records. has certificate To the Hospital or Attending Physician: funeral director, this eral Director: After filled in by the funer hours after death within 24 hours a

**Funeral** 

Director

show

-28a-f

ms 23a or must be r

and Mental Hygiene.
Is marked other than "natural", or iter

traumatic

permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic &

Physician/

Medical

notified at

the Maryland

death

Maryland 21215-0036

Baltimore,

9 Unknown	9 Unknown	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check on	nly one)
examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) Injury work?  on M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determined	128e Place of Injuny - At home form etreet feetens office	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ertifying Ph (Check 2 dedical Exar	ysician: To the best of my knowledge, death occured at the time, date and place, and d niner: On the basis of examination and/or investigation, in my opinion, death occurred at the	lue to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s) and manner stated

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

CLINTON

State Registrar

Medical

only one 29b. Signatu

and title of certifier

32. Registrar' Signat

SURRATTS

of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Terrence Halsey Clauss .05 Medical 4b. City, Town, or Location of Death Balfimore. 4a. Facility Name (if not institution, give street and number) **Examiner** Agnes tosbut-al None Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min 216 64 3083 **Director** 1 🗶 M 2 🗌 F 64 02/24/1948 Pennsvlvania show 10b. County at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified 1 Yes 2 XNo MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? ms 23a o Funeral 3117 Old Fence Road 21042 United States should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 0 other Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever ၉ Edward L. Clauss Amelia Barowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Caroline Henry/Sister 3117 Old Fence Road Ellicott City, MD 21042 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 5-7-2012 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. Dun Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of It caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between nset and Death Immediate Cause (Final Meumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last The law requires that the death certificate be Records, (4.0. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 🗌 Yes Division 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 24 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 6/2012 completed cause of death (Item 23a) (Type, Print)

20

DHMH 17 Rev 06-2011

Registrar

State

St. Agnes Hospital Baltimore, MD

ASHIMA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Amend#20b,perfuneralhome5/16/2012/ccdoh/bah Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jiz Chumbris JAMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern MARYLAW Prince Geor inton 9. Birthplace State or Foreign If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth **Funeral** Days Months (Month, Day, Year) 578-70-2123 Director 1 🗷 M 2 🗆 F 5 VARVI 10-16 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland aţ Director must be notified 1 Tes 2 No Prince MARYLAND 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 226 20746 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Medical Examiner ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔊 No Specify. Specify. "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>lanager</u> 12 utomoti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARL 20746 DANDER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or of Funeral Service License Name and Address of Facility 22. 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying burial-transif Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month Day Year 5 Other (specify) signed by the a d be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 I Unknown Completed plnods peen Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate by 1 Yes 2 No Yes 2 1 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗷 No ဂ္ 1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print

8 2012

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Shirley COHEN 201 9:39 A Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery <u>Gaithersburg</u> <u> 301 High Gables Drive #207</u> Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Approth, Day, Yell 928 Washington, DC 578-40-6465 84 Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Tes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? United States by Funeral 301 High Gables Drive #207 20878 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry National Institutes Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant of Health Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Gershongorn 17. Father's Name (First, Middle, Last) မ William Schlossenberg 19a. Informant's Name/Relationship (Type, Print)
Howard Cohen, Husband 193 Mailing Address Greet and Number of Rural Revision, Gan Thersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 05/04712 1 X Burial 2 Cremation 3 X Removal from State Other (Specify) Falls Church, VA 4 Donation King David Memorial Garden TavetringkyssHebrew Funeral Home 20012 254 Carroll St., NW, Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ars disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an iabete 124 hours after death. e Funeral Director: After this certificate has Nabed filled in by the funeral director, page 2.1 autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending 2 🗆 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) mpleted filled in by 4 Homicide determined 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) arricia Name and address of person who completed cause of death atem 23a)

Registrar

DHMH 17 Rev 7/2009

State

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	an/ iner	Decedent's Name (First, Middle,Last)		ole Carleman	_			Day Year	3. Time of Death			
a. Exam	mer	4a. Facility Name (if not institution, give	obert Josep	on Cashmai		r Location of Death	May 1, 2012		1020 hrs			
		4711 Crain Highway			Upper Mar			Prince Georg				
Funeral		5. Social Security Number 6. Sex	7. Age (li	n yrs. last birthday)	If Under 1 Ye			MM/DD/YYYY) 9. E				
Director			M 2 F	67 Y	rs. Months Da	ys Hours Min	10/28/	8/1944 Foreign Country) MA				
tay		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loc	ation				10d. Inside City Limit			
and show a	_	DC No.	ne			Washingto	. 1977					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other fraumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code			. Citizen of What Co				
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Certi	ificate of E	Death		Reg. No.				
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Daniel Gerard Coles				2. Date of De Month	Day	Year 2 3. Time mDeath 3			
	Medic	al	4a. Facility Name (if not institution, give street and number)		4b. City Town or	Location of Death		_	2 2315 hrs.\(\frac{1}{2}\)			
	Examin	er	Southern Maryland Hospital		Clint				ce Georges			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. III) 7. Age (In yrs. II	N	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th <i>y, Year]</i> <b>1949</b>	Birthplace (State or Foreign Country)			
			Usual Residence of Decedent	Yrs.			Novemb	er 14,_	Washington,D.C.			
	/land f sho	tor		ity, Town or Loca					10d. Inside City Limits			
	e Many 28a- notifie	Sirec	Maryland Prince Georges	Upper	Marlbon	0		1 X Yes 2 🗆 I				
	3 I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 2a or 28a-f show it other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 4401 Dario Road		10f. Zip Code <b>2077</b>			10g. Citizen of What Country? United States				
	r deat r iten iner r		11. Marital Status  12. Was Decedent Ever in U.S  Armed Forces? US A1  1 Never Married 2 Married 1 X Yes 2 No	.S. 13. Wa	as Decedent of Hi res, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rai Bla	ce - American Indian, ick, White, etc.			
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and	be file ental I ked o ic eve	오	Lacey Coles, Jr.					uise Yo				
Maryland	hould and M is mar		19a. Informant's Name/Relationship (Type, Print)			and Number or Ru						
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Baltimore,	Page 1 and ment of Hand in the sant: If itelery or other or others		1 X Burial 2 Cremation 3 Removal from State	Place of Disposit ceptery, crema cwland C	tory or other plac	e) May am Vetera	11,2012 ans Ceme	20c. Location tery	- City or Town, State Cheltenham, Maryland			
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-4	Physician/		Immediate Cause (Final disease or condition	elle	Res	Mila	my	tail a	Onset and Death			
	Medical Examiner		resulting in death)  a.  Due to (or as a consequence)		- 0h	struch	yo do	ne A	Tan			
	Laminer	Į.	Sequentially list conditions, b.	liva		010 41		V	-			
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	tificati ng ph	-	IF FEMALE:									
39 ×	th cer ttendii or use	jan/	23b. Was decedent pregnant 23c. If yes, outcome of pregna in the past 12 months? 1 Live Birth 2 🗆 Feta	tal death 3 🔲 I	Ectopic pregnanc	у			ate of delivery onth Day Year			
Box	the a	Physician/	1  Yes 2 No 4 Pregnant at time of a 9 Unknown	death 5 🗆 (	Other (specify)							
P.O.	requires that the death certi been signed by the attendin should be detached for use	by Pr	Part II. Other significant conditions contributing to death but not res	sulting in the unc	derlying cause giv	ven in Part I.	23e. Did t	obacco use con	tribute to the cause of death?			
Š,	uires in sign	ed b	Hypo Volenia				1 🗆	Yes 2 ☐ No	3 Probably 4 X Unknown			
of Vital Records,	as bee 2 sho	plet	- Kejpo kusim				24a. Was auto		Were autopsy findings available prior to completion of cause of			
Rec	The law ate has page 2	Completed	0				perfo	ormed? 2 <b>X</b> No	death? 1 Yes 2 No			
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?		Tail	ace of Death (Che	ck only one)					
Ę.	Physi this c	٠ <u>.</u>	1 Yes No 1 Inpatient 2 2  27. Manner of Death 28a. Date of injury	ER/Outpatient	3 DOA Othe	4 ☐ Nursing H		dence 6 Oth				
0 0	ding F th. After funer	cate	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work		280. Describe i	10W Injury Occur	red			
Division	Attendi er death ector: A by the f	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At ho	Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route								
Σ.	tal or rs afte al Dir		building, etc. (Specify	<i>y</i> )		2	Gity or Tov	vn, State)				
-	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funda after death.  To the Fundan Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination	on and/or investig	ation, in my opinio	on, death occurred	at the time, date a	and place, and di	ue to the cause(s) and manner state			
	othe lithin 2 othe lomple	M	only one) 3 Certifying Nurse Practitioner: To the best of r		leath occurred at t	he time, date and p		the cause(s) and				
	5 Witi		blear de M Thead	D2/200					6-12			
	00-		30. Name and address of person who completed cause of death (Iten	m 23a) (Type, Pri	71.0	The Pile	Cala	er Versi	121ef #100			
_	pr		ABULHASANU ANSARI		CI	Untin	nos	205	124 4100			
	Stat	te ar	31. Date filed (Month, Day, Year)  32. Registrar's Signer	ature				1	7)			

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	1.	Registrar Decedent's Name					partment of I 7/2012dhb ertificate of L	Jeani		2. Date of Dea	ıth	. 0 1	3. Time of D
ın/ cal		John 1	D. Cole	eman						Month	6 Day	201	2 0014
ner				give street and nur			4b. City, Town, o		of Death			nty of Dea	
H		Vestern Social Security N		nd Region	al Med 7. Age (In yrs.				r 24 Hrs.	8. Date of Birt	Alle		irthplace (State or i
		216-30-2		1 <b>X</b> M 2 □ F	75	Yrs.	Months Days	Hours	Min.	(Month, Day	, Yea <i>r)</i> 16,193	Co	ountry) laryland
Ļ		Jsual Residence o a. State	of Decedent 10b. County		10c. Ci	ty, Town or L	ocation	1		sept.	10/193	, r	10d. Inside City
ecto		MD	Alleg	gany	La	Vale							1 <b>X</b> Yes 2
i i	100	e. Street and Nun	mber				10f. Zip Code				10g. Citizen o	of What C	-
<b>Funeral Director</b>		8 Oakla	wn Ave	12 Was Dec	edent Ever in U.	e 112	2150 . Was Decedent of H		rigin? (Spe	cify Yes or No-			erican Indian,
by Fu		Marital Status 1 ☐ Never Marr	ied 2 🛚 Marr	Armed Fo	orces?	955	If Yes, specify Cuba	an, Mexica	in, Puerto	Rican, etc.)	В	lack, Whi	
	L	3 Uidowed		If Yes, Gir Year or D	ve Dates. 1	958	1 Yes 2 X No		/: -		Speci	eify: V	wiiice
Completed	L		cify only highe	it's Education st grade completed		(Giv	edent's Usual Occup e kind of work done DO NOT use retired)	during mos	st of worki	ng	16b. Kind of	Business	s/Industry
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To Be	17.	Father's Name (First, Middle, Last)  John David Coleman  18. Mother's Name (First, Middle, Maiden Sur  Ida Olive (Yost) Co											
-	10	John Da				105 145	iling Address (Street						
	18	Jennife			ughter	635	Lincoln S	St.,	Cumbe	erland,	MD 21	1502	ip odde)
	20	a. Method of Disp	position	3 Removal fron		Place of Disposery, cr	position (Name of rematory or other place	ce)		Date	20c. Locatio	n - City o	or Town, State
		4 Donation	5 Other (S	pecify)	Su		Memorial I			2012			nd, MD
	21	. Signature of Fu	neral Service L	La One 5	7		22. Name and Addre					2150	ice, P.A. 02
Н	23	3a. Part 1. Enter t	712	ruger,	13,	1							
			the disease, or	complications that	caused the dea	th. Do not e	nter the mode of dyir						Approximate
		shock, or hea nmediate Cause (	rt failure. List o (Final	nly orfe cause on e	ach line.		nter the mode of dyir	ng, such as	s cardiac o	or respiratory arm	rest,		Approximate Interval Betw Onset and De
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 29, 2012 April 12:45 AM Mildred P. Diamond /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Northampton Manor Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. July 27, 1921 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months 1 □ M 2 □ XF Pennsylvania 90 Director <del>183-36-6639</del> Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10c. City. Town or Location 10a, State 10b. County "natural", or Items 23a or 28a-f show 1 Tyes X No Directo Middletown Maryland | Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21769 permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene
Important: If Item 27 is marked other than "natural", or Items 23a
any Injury or other traumatic event, tra Medical Examiner meets
DRE. 4318 Valley View Road Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Faye Superfine Samuel Moss 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4318 Valley View Rd., Middletown, MD 21769 Jan Solovey / Daughter 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/1/2012 Frederick, Maryland Stauffer Crematory Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Rant. Enter the disease, or complications that glued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Finat DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Dav 4 Pregnant at time of death 5 Other (specify) been signed by the s 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the within 24 hours after deati To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20062123 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

LANCE OF 21702 196 RAYEEN BOLANUM, 01 31. Date filed (Month, Day, 32. Registrar's Signature State 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene FH TT 5/15/12 Certificate of Death 1 - State Amend#1 per Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Anna May Duley AKA Anna Mae Duley Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Hours 579-32-3565 **Director** 1 □ M 2 🛛 F 92 March 2, 1920 Bowie, Maryland Usual Residence of Decedent show 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🏻 No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  $\mathcal{DULEV}/\mathcal{HNMH}$  Baltimore, Maryland 21215-0036 Funerai 20720 USA 11613 Lanham Severn Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Own Home Homemaker 6 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Irene Crosby Gabriel Nalley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Wilton B. Duley, III / Son 11688 Lanham Severn Road, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Fort Lincoln Cemetery 5/14/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Servi 22. Name and Address of Facility 4739 Baltimore Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Castom lestimel disease or condition Medical resulting in death) **Examiner** temorrang Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 3  $\square$  Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death the a 9 Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perforr death? 1 Yes 2 No 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2XNo Hospital Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 \sqrt{Yes} 2 \sqrt{No} 1 Natural 5 Pendina Accident Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated apExaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 dertitioning Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 05/07 096 ame and address of person who completed cause of death (Item 23a) (Type, Print) Carham, MD. 20706 8118 Good Luckld. MDo Wadhwa 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 16334 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **2012** Year Physician/ 1:07AM May Clorine M. Douglas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 2010 Amberleaf Place Waldorf 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min **Director** 226-16-0946 1 M 2 X F 90 June 17, 1921 Virginia ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD. Charles Waldorf 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2010 Amberleaf Place # 13 20602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Home Maker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental F. 7 is mark ပ Charles Douglas Gladys Agee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health as Important: If item 27 is, any injury or other traunonce. Roxanne Douglas (Daughter) 2010 Amberleaf Place # 13 Waldorf, MD. 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/7/2012 **Huntt Crematory** Waldorf, Maryland 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service License 3035 Old Washington Road Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ neumor disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit that initiated events resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 ast attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death by the Unknown g 🗌 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a, Was an or Attending Physician: The law prior to completion of cause of death? autopsy this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A Accident
Sulcide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) fress of person who completed cause of death (Item 23a) (Type, Print) 9 2012 Registrar

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Ų	Physici /Medio		Lorretta Ann Da	arr				Month 5	3 Day	2012	9:40	РМ
	Examin	er	4a. Facility Name (If not institution, give si			4b. City, Town, or		of Death		ounty of Death	_	
			528 Brunswick Str. 5. Social Security Number 6. Sex		(In yrs. last birthday)	Bruns If Under 1 Year		24 Hrs. 8. Date of E		ederic	place (State or	Foreign
п	Funeral Director			M 077 F	70 Yrs.	Months Days	Hours	Min. (Month, 1/12	7942 1942	Col	piace (State of	roreigir
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	how		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside Cit	•
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Maryland	should nd Me mark matic	ပ္	Norman Danner  19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailii	na Address (Street		er or Rural Route Nun	nber, City or T	own, State, Z	ip Code)	
N N	nd 2 tallth ar 27 le		Donald Darr, Husba	_	528	Brunswick	Stre	et, Brunsv	vick MD	2171	6	
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Ë	Page nent c		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Knoxville I			5/7/2012	Knoxv.	ille MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Items 23a or 28a-f show supprignty or other traumatic event, I'm Madical Examinat must be notified at once.		21. Signature of Funeral Service License	IMA DA	22	2. Name and Addres	ss of Facilit		<b>.</b>	1 15 0	1 T4 C	
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	To the within 2 To the complet	Mec	29b. Signature and little of certifier	and manner side		29c. Licens	e number		29d. Date	signed (Montl	n, Day, Year)	*
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-	6		30 Name and address of person who con	npleted cause of de	ath (Item 23a) (Type,	Print) D			1/1/			
	9			NUM, 19	6TIDR	CUE, TRI	600	rece, MI	217	02		
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 7 20	32. Registrar	's Signature	backer		PCCC M				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mayth Physician/ L. 06 2012a 09:44 Ам Dillinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 1809 Keymar Road Edgewater . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 48 218-88-1826 1 □ M 2 □XF Director 10/07/1963 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🕅 No Edgewater Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 United States 1809 Keymar Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 **X**No 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) P.G. County Schools Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Lee Tollev Delores Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Dillinger/Husband 1809 Keymar Road, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Hillcrest Memorial Cen. 05/10/2012 Annapolis, Maryland on 5 Other (Specify) 4 Donat 21. Signatuj 22. Name and Address of Facility George P. Kalas Funeral Home of Funeral Service Licensee alas 2973 Solomons Island Road, MD 21037 Edgewater. Part 1. Enter the disease of sheck, or heart failure. List or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin attending physician and for use as the burial-transit Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 XNatural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ompleted cause of

Registrar
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State

31. Date filed (Month, Day, Year,

8 2012

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lois Stevens Dawson 2012 May 12:47 AM Medical a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days 229-56-3392 Director 1 M 2XX Oct. 8, 1940 Virginia Usual Residence of Dec show 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a Maryland Anne Arundel Annapolis 1 Yes XX No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1746 Long Green Court 21409 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces Black, White, etc. 9 1 ☐ Yes 2 🗷 No If Yes, Give by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates r than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other the ury or other traumatic event, the I Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Stevens Mary Pritchett ٥. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Dawson/husband 1746 Long Green Court Annapolis, Maryland Department of Health Important: If item 27 any injury or other to once. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 5/10/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signatur ral Se de Censee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death should be detached g 🗌 Unknown the q Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Inhnown Completed 24b Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy perform death? 2 🗌 No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? s after death. 2 🗌 No ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier completely (Check з 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year

Registrar

DHMH 17 Rev 06-2011

State

m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2012

Ste 210 Annano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g928 6-8-12 sm State of Maryland / Department of Health and Mental Hygiene - State Amend#10eper FH TT 5/15/16 Pertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ DEMPSEY, JR. JAMES OTEY 6, 2012 2116 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 578-70-6459 59 October 19, 1952 Washington, DC Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No Montgomery Silver Spring 10e Street and Number 2207 Glenallan Ave APT.#201 <del>2209 Glen Allen Avenue</del> 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married ò 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Şecondary (0-12) 12th College (1-4 or 5+) the Private Metro Operator other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Otey Dempsey, Sr. Theresa Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 1725 17th Street, NW, #408, Washington, DC Greta Dempsey, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory May 14, 2012 Beltsville, Maryland 4 Donation 5 Other (Specify) 21. Signature Timeral Silvice Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Cardiomyopathy Sequentially list conditions, Examine Due to jor as a consequence of cause. Enter Underlying CECTIFICATION APPROVED BY MEDICAL EXAMINER requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events Coronary Arteriosclesosis Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day ed by the at detached fi Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Alcoholism 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law page 2 has autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) niner? Hospital: 1 X Yes 2 X Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🕱 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 6, 2012 00 D52503 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910-1484 Shailesh Sheth, 31. Date filed (Month, Day, Year) Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **EDNA** FAYE DAWSON 2012 8:00 A M MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 02-04-1948 Hours Min **Director** 224-66-2556 1 □ M 2 🗶 F 64 NC Yrs Usual Residence of Dece ems 23a or 28a-f show r must be notified at show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director DC WASHINGTON 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3423 5th with 1 Funeral STREET SE, 20032 US death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2X No Specify BLACK Specify "natural" 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the BENEFITS SPECIALIST FEDERAL GOVERNMENT other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be UNKNOWN EDNA COOK and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, of Health of item 27 3423 5 JASMIN JAMES/DAUGHTER STREET SE, #T13, WASHINGTON, DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HERITAGE MEMORIAL MAY 11,2012 WALDORF, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ RESPIRATORY INSUFFICIENCY Medical Due to (or as a consequence of) Examiner MALIGANT PLEURAL EFFUSION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): METASTATIC BREAST CANCER as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate I ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 XNo 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and titly 29d. Date signed (Month, Day, Year) 0 29c. License number D0055149 who completed cause of death (Item 23a) (Type, Print) WILLIAM C. LAMERMAN, M.D. 1500 FOREST GLEN ROAD, SILVER SPRING, MD 20910 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin	er	4a. Facility Name (i	if not institution, giv	ve street and number)	151	forms	4b. City, Town, o	a Park				y of Death <b>GOMELT</b>	County
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	<ul><li>11. Marital Status</li><li>1 X Never Mar</li><li>3 ☐ Widowed</li></ul>	ried 2  Married	12. Was Decedent I Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	Ever in U.S No	5. 13	I. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, P	? (Specify Yes or No- perto Rican, etc.)  14. Race - Al Black, W.  Specify: <b>B</b>				etc.
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	23b. Was decedent in the past 12 1  Yes 2 9  Unknowr	months?		2 Feta	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су				ate of delive onth	Day Year
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	Funeral Director		5. Social Security Number 6. Sec. 2.17 - 32 - 1613 1	7. Age (In yrs	Mon	nder 1 Year   If Under 2	4 Hrs. 8. Date of Bi Min. (Month, D	irth	Birthplace (State or Foreign Country)
200		'n	Usual Residence of Decedent  10a. State 10b. County		Yrs.		7-18	? - 36	Maryland 10d. Inside City Limits
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Maryland Charle		Waldorf				1 Yes 2 No
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21215-0036	ours afte tural", c al Exam	ted by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		s 2 🗖 No Specify:		Specify:	
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Baltimore,	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature   F neral Service Licerise		H. MAIZYS	and Address of Facility	5-10-12	Bryant	own Macyard
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68760	tificate to ng physi	Medic	IF FEMALE:						
Box 6	In the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of	tal death 3 - Ector	ic pregnancy (specify)		23d. Dat Mor	e of delivery nth Day Year
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Tal B	sician: The law r s certificate has b director, page 2 s		25. Was case referred to medical examiner?			26. Place of Death			Yes 2 No
) V	Physic r this ce eral dire	ျှ	1 ☐ Yes 2 📈 No Ho  27. Manner of Death	ospital:  1  Inpatient 2   28a. Date of injury	ER/Outpatient 3 28b. Time of	DOA Other: 4 Nurs	ing Home 5 Resi		
ion	I or Attending Ph after death. Director: After thi d in by the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury M	work? 1 \( \sum \text{ Yes}  2 \sum \text{ No.} \)	- 1	how injury occurre	eg .
Division of Vital	al or At s after o		4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, street, fac	ory, office	28f. Location ( City or Tou		r or Rural Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 L. J Medical Examine	ian: To the best of my knower: On the basis of examination	on and/or investigation.	in my opinion, death occur	rred at the time date :	and place and due	to the cause(s) and manner stated
	To the within To the	2	29b Signature and title of certifier	Practitioner: To the best of		9c. License number	and place, and due to		anner as stated. (Month, Day, Year)
	400		30 Name and address of person who cor	npleted cause of death (Ite	n 23a) (Type Print)	R13510	CR (1)	5/3	110
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	Stat Registra	e ir	31. Date filed (Month, Day, Year) 7 20	32. Fegistrar's Signa	A. back				

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Registrar

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31. Date filed (Month, Day, Year) MAY 0 3

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32. Registrar's Signature

Ct. Hagarstown

Registrar
DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD.

State 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

May 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28 Leona Julia Dennison April 2012 4:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN NURSING AND REHABILITATION BERLIN If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** Months Hours 1 🗌 M 2 🗶 12/23/1922 Maryland 89 Director 219-16-4856 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Berlin Maryland Worcester 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? USA Funeral 21811 9715 Healthway Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Department of Health and Mental Hygnes Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) University Secretary Be Page 1 and 2 should be filed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Anna Lowe Leona Jenkins Tayman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Hoffmaster/Granddaughter 7553 Gumboro Rd., Pittsville, MD 21850 Dennison, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of H cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/3/2012 Pittsville, MD Donation 5 Other (Specify) Pittsville Cemetery Signature of Funeral Service Licenses 22 No. 12 and Address of Lacilly all Home Professional Association and oft. 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between set and Death Immediate Cause (Final Pnysician 10 disease or condition resulting in death) Medical Du 7 o (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 ned by the attending property detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death ☐ Pregnani . ☐ Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 ☐ Yes 2 X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25, Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year, April 30, 2012

State

DHMH 17 Rev 7/2009

Registrar

21811

William H. Robuns, MD, 9715 Healthway Dr, Berlin,

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MA)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas						<b>k. Ensure A</b> Health and N	-		gible.				
	_	For State Registrar			- Trial yie		,	ate of			eg. No. 2 (	112	16	345		
Physician		1. Decedent's Name Char		_{.ast)} lard Ecc	ard					2. Date of Deat	h 2 2	OIZ	3. Time o	of Death P		
Medica Examine		4a. Facility Name (if Meritus		ive street and nun 1 Center			4b. (	City, Town, o	or Location of Death	9	4c. County	of Death ashin				
Funeral Director		5. Social Security Nu. 214-28-50 Usual Residence o	44	Sex 1 <b>X</b> □ M 2 □ F	7. Age (In yrs	: last birtho	Mon	nder 1 Year ths Days		8. Date of Birth (Month, Day, April23	Year)	Count	lace (State ry) y 1 an d	or Fo <b>re</b> ign		
f show		10a. State	10b. County	• •	10c. 0	City, Town o						11	Od. Inside C			
he Maryland or 28a-f sho notified at		Md.  10e. Street and Num	Frede	rick		Smī	thsbu	rg . Zip Code			1 ☐ Yes 2 💢 No 10g. Citizen of What Country?					
ns 23a nust be	runeral	3843 Forr	est Sch	ool Rd.					1783		U.S.A					
min in	2	11. Marital Status 1 ☐ Never Marri 3 ☐ <b>X</b> Widowed		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 <b>X</b> No e	J.S.	If Yes,	specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
72 hour	Completed	(Spec	15. Decedent's cify only highest	Education grade completed)	life DO NOT use retired)						16b. Kind of B	usiness/Ind	lustry			
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Mental Hyg Nental Hyg narked othe atic event,		17. Father's Name (F Noah E		t)					18. Mother's Nam Amy Al	e (First, Middle, M ice Mill		e)				
nd 2 shou lealth and m 27 is m her traum		19a. Informant's Na Regina Mi	ss (Dau		ck Rd. My	al Route Number,	City or Town, S. Md. 2	State, Zip C 1773	ode)							
Page 1 a		20a. Method of Disp 1 X Burial 2 I 4 Donation	Cremation 3	Removal from	State Ga	Place of E cemetery YT161	d Uni	or other pla	May 20	^{Dat} 18,	Garfield, Md.					
Depart Import any inj		21. Signature of Fun	eral Service Lice	1 1000	MO ج	1414	J.L.	e and Addre	Cem. 20 ess of Facility s Funeral			5 Bradbury Ave. nsburg,Md. 21783				
hysician/		art 1. Enter the shock, or hear Immediate Cause (Find disease or conditions)	t failure. List only Final	one cause on ea	ch line.				ng, such as cardiac	or respiratory arre		. 9,1.0	Approxima Interval Be Onset and	ate etween		
Medical Examiner		resulting in death)		Due to	or a a conse	quence of)		1	Failu	, ,						
and transit		Sequentially list cor it any, leading to im- cause. Enter Under Cause (Disease or i	lying njury						D17 649							
ysician and e burial-tra	ز	that initiated events resulting in death) L		Due to	or as a conse	quence of)	:									
ding physe as th		IF FEMALE:		23c. If yes, out	come of pred	nancy										
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-Madical Certificate. To Re Completed by Divisional Filled in Section 20 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15	Igalora	23b. Was decedent print the past 12 mm 1 Yes 2 Tes 2 T	nonths?	1 🔲 Live	Birth 2 🗌 Fe nant at time o	etal death		pic pregnan er (specify) _	icy			ate of delive	ry Day	Year		
gned by be deta	2	Part II. Other signifi	-	0	eath but not r	esulting in t	the underly	ing cause g	iven in Part I.		pacco use conf					
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cate has been si										24a. Was ar autops perforr 1 Yes	med?	Were autop prior to con death? 1  Yes	npletion of			
certifi	ا دُ	25. Was case referre examiner? 1 ☐ Yes 2 2 🔀	-	Hospital:	` _ r	7		Oth	Place of Death (Check				·-			
after death.  Director: After this clin by the funeral din		27. Manner of Death  1 Natural 2 Accident		28a. Date (Mon	Inpatient 2 [ of injury th, Day, Year)	28b. Tin	ne of	28c. Inju	ry at	ome 5 Reside 28d. Describe ho						
al Directo ed in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	t be 28e. Place	of Injury - At ng, etc. (Spec	home, farm	, street, fac	ctory, office		28f. Location (St. City or Town		er or Rural	Route Num	ber,		
e Funera letely filla	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.											anner stated.				
To the comp.		29b. Signature and t			I TO THE DEST O	. Try KITOWIE	Age, death	29c. Licens			9d. Date signe					

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 16, 2012 4:20 M Melvin Galen Folk /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Moran Manor Westernport 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Country) Maryland **Funeral** Days Hours Min 1 M 2 □ F June 30, 1955 218-64-9274 56 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic even." 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Director Lonaconing Maryland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21539 USA 32 Island Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Garage Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Yvonne Bradburn Melvin Folk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Terry Davidson-Sister 32 Island Street, Lonaconing, Maryland, 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) Date May 18 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State **Cumberland Crematory** Cumberland, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539 8 East Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cenebro - vasculer scilet (5+ rola Immediate Cause (Final Lays **Physician** went disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Veal in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? dys nha 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 2 ER/Outpatient 3 DOA 1 Inpatient ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation Natural 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 2 3 2012

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Ian MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

121244

29d. Date signed (Month, Day, Year)

and manner stated.

Sroadkian 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012^{Yea} Marilyn May France E 5:35 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles 2710 Pinewood Drive Waldorf Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 213 46 7641 1 □ M 2 Ϊ 68 April 24, 1944 Washington DC Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director · 28a-f 1 Yes 2 X No Waldorf Maryland Charles 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be 1 Funeral United States 2710 Pinewood Drive 20601 Was Deceue... Armed Forces? 1 Yes 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Ment, Important: If Item 27 is any injury or Mary Ellen Gue Harry Fenton Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Pinewood Drive, Waldorf, MD 20601 Ronnie T. France, Sr. (husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery 5/11/2012 Suitland, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton. 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delive 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 9 Unknow P.O. signed by ti 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be Place of Death (Check only one. examiner? 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of : After t Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accider 5 Pending 1 Yes 2 No r death. within 24 hours after death

To the Funeral Director: / Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner

State

29b. Signature

Date filed (Mc

eted cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:40 AM 2012 Helen Marian Ferris Medical County of Death Equility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LATA HARLES If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral Months Days Hours Min Delaware 1 □ M 2 😿 F Director 221-16-2274 Usual Residence of Decedent 10b. County 10d. Inside City Limits notified at 10a. State 10c City Town or Location Director 28a-f 1 ☐ Yes 2 🛣 No Charles Cobb Island Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 16768 Gridiron Road 20625 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 Married  $Merce \mathcal{N} \mathcal{N}^{-}$ 1 ☐ Yes 2 ▼ No Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural" Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Fage 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medi (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Klosowski Viola Klosowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Ramey/Executor Box308 Cobb Island, Maryland 20625 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols 05-09-2012 | Charlotte Hall, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A David C. Ech La Plata, MD 20646 M00945 Mary's Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 🗌 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 1 Dunpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 2 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 5,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rowell

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ May 12^{Day} 2012 0347  $A^{M}$ Charles Junior Grubb Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci1 E1kton Union Hospital 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours April 26, Months Tennessee Î926 86 Director 212-28-2531 Usual Residence of Deceden show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🟋 No Maryland Chesapeake City Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21915 43 Buddy Boulevard death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Automobile permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Assembler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy Alice Poe Charles Grubb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louise M. Grubb/Wife Post Office Box 623, Chesapeake City, MD 20b. Place of Disposition (Name of Cherry HIII)
Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition May 16 1 Burial 2 Cremation 3 Removal from State Cherry Hill, MD 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 21921 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Equantially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Yes signed by the a 1 Yes 2 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No certificate 26. Place of Death (Check only one) or Attending Physician: funeral director, 25. Was case referred to medical Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 🗌 Yes ဂ 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this or completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, 00060756

State Registrar 30. Name and address of pers

31. Date filed (Month, Day, Year)

3 2012

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completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day 02 Year 2 Physician/ 7:45 Рм Ruth Reynolds Gamble Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Calvert Manor Healthcare Center Rising Sun If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number 1 □ M 2 🝊 F Days Hours Country) 9/10/1923 88 MD Director 221-14-8711 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No MD Cecil Rising Sun 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 736 Hopewell Road 21911 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Anna McVey Curtis Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45 Pine Valley Road, Elkton, MD 21921 Nancy Williams - Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Brookview Cemetery 5/8/2012 Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee S. Queen St., Rising Sun, MD 21911 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Amyotrophi Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a sonsequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 1 Yes 2 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2**℃** № 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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DHMH 17 Rev 7/2009

State Registrar (Check

only one

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O.,

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32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

COLONIAL

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1 2012 9:15James Edgar Grimes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Director 214-13-3388 1**X**□ M 2 □ F 25 Yrs Nov. 14, 1986 Maryland Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 Yes 2 No Maryland Frederick Thurmont 10f. Zip Code 21788 10e. Street and Number 10g. Citizen of What Country? 102 Dogwood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). General Worker 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry l Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h Hank Grimes ပ Deborah Hornick Department of Health and Ment: Important: If item 27 is marked any injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Dogwood Ave. Thurmont, MD 21788 Debbie Combs/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Resthaven Mem Park 5/2/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licent 104 E.Main Street, Thurmont, MD 21788 1. Inter the dise ve. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition moental Medical resulting in death) Due to (o s a consequence o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence oi): the burial-transi resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown a | Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0030020 2012 physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 , waltersville, Md. Shothe Miss PO Box John 310

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 5:25 A JOHN CLEVELAND GRAY MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES RESIDENCE. 5800 ANNAPOLIS ROAD #504 BLADENSBURG If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 1**X** M 2 □ F 218-16-3353 FEBRUARY 25,1925 MARYLAND 87 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director 1 X Yes 2 No MARYLAND PRINCE GEORGES BLADENSBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 23a Funeral 5800 ANNAPOLIS ROAD #504 20710 UNITED STATES items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Examiner med Forces?
Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1943 1 Never Married 2 Married 5 2 filed within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1946 1 ☐ Yes 2 XNo Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. 12TH GRADE (0-12) College (1-4 or 5+) the LAB ASSISTANT MEDICAL alth and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P SYLVESTER GRAY ALBERTA SMALLWOOD GRAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tranonce. MARGARET JUANITA GRAY / WIFE 5800 ANNAPOLIS ROAD,#504, BLADENSBURG, MARYLAND 20710 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State MARYLAND VEIERANS CEMETERY MAY 14, 2012 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Eurieral Service Licensee THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN LYDIA C. THORNTON JOHNSON MO0583 HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine -tran and resulting in death) Last the burial physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify, Hospital 1 Yes 2X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director; After this of filled in by the funeral dil After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Fune completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

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Name and address

31. Date filed (Monti

VICKEN POOCHIKIAN, MD

5632 ANNAPOLIS RD.,

f person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signatur

D34722

MAY 8, 2012

SUITE 3, BLADENSBURG, MD 20710

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May Alfred Green, 2012 John Jr. 4:52 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1437 Washington Avenue Severn Anne Arundel Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 579-50-0558 Director 1 🗶 M 2 🗆 F Washington, DC 73 11-11-1938 Usual Residence of Decede 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Tes 2 No MD Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? an "natural", or items 23. Medical Examiner must USA 1437 Washington Avenue 21144 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Force Black, White, etc. 1 Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Auto Tow Truck Operator Auto Towing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Page 1 and 2 should be Alfred Green, Sr. Mary Catherine Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6018 Drum Point Road, Deale, MD 20751 Joyce A. White, Sister item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-12-2012 Alexandria, VA Metropolitan Crematory re of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ schemic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). the attending physician and hed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 XNo Yes 2 X No 1 Tyes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injun work? Investigation М 2  $\square$  No 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Levi

exande 31. Date filed (Month, Day, Year) 32. Registrat State Registrar

erson who completed cause of death (Item 23a) (Type, Print)

5

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29b. Signature and title of

30. Name and addressed

29c. License number

1996

Year

29d. Date signed (Month, Day, Year)

Rockville, hus zun

Suite 201

Registrar DHMH 17 Rev 06-2011

Box 68760

P.O.

Records,

Division of Vital

Debrah Miller, CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $1355\,$  Piccard Drive, Rockville, MD 20850

Registrar's Signature

31. Date filed (Month, Day, Year,

MAY 04 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	arylan	d / Depa	artment of	Health	and N	Mental H	ygiene		
			Registrar				Cer	tificate of	Death			Reg. No. 2	012	1635
	Physic Med	ian/ lical		Ro	bert Wood	Heat	h, Sr.				2. Date of D	eath	2012	3. Time of Death
	Exam	iner		ot institution, give	street and number)		,	4b. City, Town, o	or Location	of Death	1 ray	4c. Count		1029 A M
			Union Hos					E1kton					cil	
	Funera Directo		5. Social Security Num	ber 6, S	X MA O TO		st birthday)	If Under 1 Year	If Under		8. Date of Bi	rth		lace (State or Foreign
			215-28-24 Usual Residence of De		8C	)	Yrs.	Months Days	Hours	Min.	July (	^{3y, Ye} <b>1</b> 931	9Ma	ryland
	and show	5		0b. County		10c City	, Town or Loc	-M						
	laryla Ba-f s	ecti	Maryland	Cood 1				ation					11	0d. Inside City Limits
	or 28	盲	10e. Street and Number	Cecil		EI	kton	1						1 🛚 Yes 2 🗌 No
	with 23a set b	era	_500 Delaw		210			10f. Zip Code				10g. Citizen of	What Count	try?
	eath tems er mu	Funeral Director	11. Marital Status	die Ave	12. Was Decedent Fr	ver in L1S	12 14	21921				Unite	ed Sta	ates
98	or i	À	1 Never Married	2 X Married	Armed Forces? 1	<u> 950-</u>	"	as Decedent of H Yes, specify Cuba	ispanic Ong in, Mexican	in? (Spe , <b>P</b> uerto l	cify Yes or No- Rican, etc.)		e - America ck, White, e	
21215-0036	ursa ural" al Exa	Completed	3 Widowed 4	Divorced	If Yes, Give Year or Dates.	~1952	2 1	☐ Yes 2 🔀 No	Specify:			Specify:		
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12	thin 7	l e	Elementary/Second	ay (0-12)	College (1-4 or 5+	-)	(Give ki life. DO	nd of work done o NOT use retired)	during most	of workir	g	16b. Kind of B	usiness ingi	ustry
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an	ontal I	100	17. Father's Name (First		. 1				18. Mothe	r's Name	(First, Middle,	Maiden Surname	e)	ar rocate
₹	ould d Me marl mati	1	Harry Gar						Cha	r1ot	te Wood	d		
Maryland	2 sh Ith ar 27 is trau	1	19a. Informant's Name. Anita M.			1	19b. Mailing	Address (Street a	nd Number	or Rural	Route Numbe	r, City or Town, S	tate, Zip Co	ode)
<u> 5</u>	l and f Hea item other		20a. Method of Disposit		.re	1001 51	500 1	elaware	Avenu	ıe, E	lkton,	MD 219	921	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🕅 Burial 2 🗆 C	remation 3 🗇	Removal from State	Cher	ce of Disposi netery, orema	tion (Name of tory or other place	e)   1	May □	ite.	20c. Location -	City or Tow	n, State
Ħ	nit. F		4 Donation 5 21. Signature of Funeral			Meth	odist	cemeter	v   1	2012		Chei	rry Hi	ill, MD
ä	Der Imp any onc			October Licerise	ا الله		22.1	Name and Addres	s of Facility	Hic	cks Hom	e for Fi	ınera	
			23a. Part 1. Enter the d shock, or heart fail	isease, or compli	cations that caused the	no donth I	20 224 224	100 W.	SLOCKI	on S	treet,	Elkton,	, MD	21921
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	Medical		disease or condition resulting in death)	a 8	- (50	dio	10	arrest	- 2 j	VIO	nonay	grey		Onset and Death
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3	ian ar	<u> </u>	resulting in death) Last		Due to (or as a c	onsequen	ce of):							
Box 68760	physician and the burial-transit	Completed by Physician/Medical Examiner		d										
687	ing p	Me	F FEMALE:											
Box (	been signed by the attending should be detached for use as	ian/	23b. Was decedent pregr in the past 12 month	nant 23	c. If yes, outcome of p	pregnancy Fetal de	eath 3 🗆 E	ctonic prognancy				23d Date	of delivery	
<b>m</b>	the a	ysic	1 Yes 2 No	10:	4 Pregnant at tir	ne of deat	h 5 0	ther (specify)				Mont		y Year
P.O.	ed by detac	된	Part II. Other significant	conditions cont						_	_			
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e law	cate has	립									24a. Was an		ere autopsy	findings available etion of cause of
7 5	certificate l rector, page		5. Was case referred to r								perform	ned? dea	ath?	
Division of Vital Records,	r this certificaral director, p	To Be	examiner?		spital:				of Death (	Check on				
of of	eral o		7. Manner of Death		1/2 Inpatient 28a. Date of injury		Outpatient 3 Time of		4 Nursi	ng Home	5 Resider	nce 6 Other	(Specify)	
On ordin	ath. r; After e funer	cat	16 Natural 5 2 Accident	Pending Investigation	(Month, Day, Ye	ar)	injury	28c. Injury at work?			. Describe hov	v injury occurred		
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lospi	within 24 hours after death.  To the Funeral Director, After this certificate has been signed by th completed filled in by the funeral director, page 2 should be detached.	Medicar	9a. Certifier 1	rtifying Physicia	in: To the best of my leads to the basis of exami	knowledge	, death occu	red at the time, da	ate and plac	e and di	io to the course	2/2)		
the P	hin 2.		only one) 3 Ce	rtifying Nurse P	On the basis of exami ractioner: To the best	nation and of my know	or investigati wledge, death	on, in my opinion, o	death occurr	ed at the	time, date and	place, and due to	is stated. the cause(s	and manner stated.
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4	11	30	). Name and address of p	person who comp	eleted cause of death	(Item 23a)						- / - /		
V	01	31	. Date filed (Month, Day,	ohn	Billo	22	W. !!	204	Son	the 5	+ El	5/14/.	202	-1921
	State Registrar		MAY 2 3 20		32. Registrar's S	ignature	1							<u>-</u>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 8 per FD, DOR, Registrar 5/17/12, LDB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:53PM Physician/ Robert Lee Hitchens Medical Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death **Examiner** alisbury NICOMICO oastal 2100 If Under 1 Year If Under 24 14 Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours 215-26-4531 80 Maryland Director 1 X M 2 D F Vrs Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No Fruitland Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21826 USA 509 Hayward Avenue 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? 1 Xyes 2 No 1950 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White 1951 3 XWidowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Residential and I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Painter Industrial Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ပ Bessie Mae Quillen William Byrd Hitchens injury or other traumatic Page 1 and 2 should in πent of Health and Με 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 24930 Delmar Road, Mardela Springs, MD 21837 Linda J. Abbott/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State Salisbury, Maryland 5/9/2012 Parsons Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. 0 1212 01d Ocean City Road, 21. Sign dare of uneral Service Lice 0. Box 3171 d, Salisbury MD 21802 a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians MALIGNANT CAR CINDULA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funezral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death □ Pregnant .
□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> B Probably 4 Unknown 1 🗌 Yes 2 No Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2/☐Ro 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 Ro Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICA 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Y

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#1 per PHY State Registra5/4/2012 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) Lumiko Hryzan 2. Date of Death 3. Time of Death Physician/ Month Year 46 pm Medical 7) \ a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death mery universit Baltimor 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday Hours 59 Days Min 139-46-4792 Director 1 □ M 2 🗶 F June 01,1952 Japan Usual Residence of Dece 28a-f show 10b. County notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Crofton MD 1 Yes 2 XNo ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral USA 21114 1721 East Bancroft Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White "natural", Completed 3 X Widowed 4 Divorced Specify: Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Registered Nurse Health Care other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk and Mental I is marked or ည Grace Hege Leopold Fontenot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Lamoka Drive Odenton, MD 21113 e 1 and 2 sl of Health a If item 27 is Heather Charpiat/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate 23. Department of Important: If it any injury or o 1 

Burial 2 

Cremation 3 

Removal from State Metro Crematory, Baltimore, MD INC. 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee P.A. Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter repolisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ aver disease or condition ta Medical resulting in death) Due to (or as a consequence of): Examiner 52 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to ( r as a consequence of): Exami varevocal death certificate be executed etastalic that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Pregnant at time of death Unknown 9 Unknown Hospital or Attending Physician: The law requires that the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy performed certificate 2 No 1 Yes ours after death. eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred iniurv work? 1 Natural 5 Pending 2 Accident 2 🗀 No Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the** I only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) mary D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Batuni 1/2 31. Date filed (Month, Day, Year, 32. Re strar's Signature State MAY 04 2012 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Day Physician/ 2012 Year Gerald Kelly Hinch Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing & Wellness Ctr Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 326-28-8847 Director 1 **№** M 2 🗆 F 76 Dec. 10, 1935 NY Usual Residence of Decedent or than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15109 Manor Lake Drive 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married Completed by Specify Black ☐ Yes 2 🖾 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 H No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 In and Mental Hygiene. 7 Is marked other than "1 College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Deputy Assistant Secretary Federal Government other treumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 Is marked otherly injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gerald Hinch Jasmine Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) U-N Silver Spring, MD 20906 Janice Hinch/Wife 3310 N. Leisure World Blvd., Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State May 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA Metropolitan Crematory 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service License Francis J. Collins Funeral Home Inc. In the CMU 500 University Blvd. W., Silver Spring Part 1 finter into disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Urinary Tract Infection disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Alzheimer's Dementia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury oburial-transit Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use es the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 No ate has been signed by the a page 2 should be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 2 XN Hospital or Attending Physician: funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☒ No Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 XX Natural 5 🗌 Pending injury 2 Accident 2 🗌 No Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State) Medical Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

3. Time Death

рм

9:15

10d. Inside City Limits

1 Yes 2 X No

MD 20901

**Approximate** 

week

Day

29d. Date signed (Month, Day, Year)

May 2, 2012

State Registrar

10

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Piyush Patel, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

DHMH 17 Rev 06-2011

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

19745 Executive Park Circle, Germantown , MD 20874

D56345

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State		State of M	larylar	-				and M	lental Hy	gien	ie			
			Registrar  1. Decedent's Name (First, N	1iddle, La	st)	_	Cei	tificate	or D	eatn		2. Date of De	Reg. I	No. 2 (	112		635
	Physicia		Henry Halle	,								Month		14 2	0 ^Y 1°2	161	1 M
may	Medic Examir		4a. Facility Name (if not instit	ution, giv	e street and number)			4b. City, T	own, or L	Location	of Death			4c. County	of Death		
To the same			Suburban Hos	pita	1			Beth	esda	a			- 1	Montg		7	
	Funeral		5. Social Security Number	6. \$			ast birthday)	If Under	Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th	•)	9. Birthp		e or Foreign
	Director		350-18-4906 Usual Residence of Decede		<b>X</b> M 2 □ F	88	Yrs.					6-16-			-	nany	
	and show	ē	10a. State 10b. Co			10c. Cit	ty, Town or Lo	cation							1	0d. Inside	City Limits
	Mary 28a-f otifie	rec	MD Mon	tgom	ery	Ro	ckville	9								1 🗓	Yes 2 □ No
	h the	a D	10e, Street and Number					10f. Zip (						Citizen of V			
	ms 2%	Funeral Director	1801 E. Jeff	erso					852					ited			
Baltimore, Maryland 21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 🛭 3 ☐ Widowed 4 ☐ Divo		12. Was Decedent Armed Forces? 1 \( \overline{A} \) Yes 2 \( \overline{D} \) If Yes, Give Year or Dates.		II   '	Vas Decede f Yes, specif				cify Yes or No- Rican, etc.)		Blac	e - Americ k, White, e WHI	etc.	
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d 2	led within Hygiene. other than ent, the N	Be (	17. Father's Name (First, Mide		2.1		ricciiai	ircar				(First, Middle,					
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ary	2 should be file th and Mental H 27 is marked of traumatic ever	35	19a. Informant's Name/Relat	ionship (	Type, Print)		19b. Mailin	g Address (	Street an	nd Numbe	er or Rural	Route Numbe	r, City	or Town, S	tate, Zip C	ode)	
Σ	1 and 2 s of Health iftem 27 i		Ruth Halle -	Wif	e 	_	1801	E. Je	ffer	cson	#621	, Rock	vil:	le, M	ary1a	and 2	0852
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Ba	permit. Page 1 Department of Important: If i any injury or o	e e	21. Signature of Funeral Serv	ice Licen	see Edward	Sage		. Name and $170~{ m Rc}$				Danzan , Rock	-		_	and 2	0852
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387	rtificar ing ph e as t	/Me	IF FEMALE:	- 1												_	
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Completely filled in by the funeral director, page 2 should be detached for use as the burlal-tranging physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-tranging.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	160	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	II death 3	Ectopic pro Other (spe						23d. Date Mor	e of delive nth	ry Day	Year
P. 0.	that t ned b e deta	by P	Part II. Other significant con	ditions o	ontributing to death t	out not res	ulting in the u	nderlying ca	use giver	n in Part	l.	23e. Did to	bacco	use contri	bute to the	e cause o	f death?
ds,	quires en sig ould b											1 🗆	Yes :	2 🗌 No	3 🗌 Prob	ably 4X	Unknown
Division of Vital Records, P.O.	has be ge 2 sho	Completed										24a. Was	osy	p	rior to cor		s available f cause of
Ä	hysician: The lav nis certificate has I director, page 2											1 Yes	rmed? 2 X		eath?	2 🗆 No	
ita	siciar certif irecto	m	25. Was case referred to med examiner? 1 ☐ Yes 2 X No	ical	Hospital:				10		th (Check						
of <	iding Phy: th. After this funeral d	e: 10	27. Manner of Death		28a. Date of inju	ıry	ER/Outpatien 28b. Time of	$\overline{}$	. Injury a	4 ∟ Nı		ne 5 🗌 Resid 8d. Describe h					
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	5	0 1	Enrique Daza 31. Date filed (Month, Day, Yea						#220	00,	Bethe	sda, M	ary	1and	2081	7	
	Stat Registra	-	MAY 07		2. Registra	ar's Signat	far far	w.							,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0700 James W. Hutchinson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1072 Mt. Airy Road Davidsonville Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 219-46-7380 1 XM 2 □ F 67 3/24/1945 Illinois Usual Residence of Deceden 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified SC Lancaster 1 Yes 2 No Lancaster 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1341 Kent Drive 29720 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 and Mental Hygiene.
and Mental Hygiene.
/ is marked other than "natural", 1 ☐ Yes 2 X No Specify White Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Elementary/Secondary (0-12) College (1-4 or 5+) filed within tal Hygiene. other traumatic event, the Defense 4 years Auditor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other **** မ Owen Hutchinson Barbara Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1341 Kent Drive, Lancaster, Linda G. Hutchinson/ Wife SC 29720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 5/8/12 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus Savice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cau at n each line. Interval Between Onset and Death Immediate Cause (Final terroscierotze SEASE Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-trar resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes 2 No g Unknown 9 Unknown ò been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Secondary Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 🔲 Yes 2 🗌 No after death. within 24 hours after death

To the Funeral Director: A
completely filled in by the Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 1051

Registrar DHMH 17 Rev 06-2011

State

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Certificate of Death Registrar 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ April Day 2012 23, 8:10 Helen Jackson Harrington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 324 Harrington Road Rising Sun If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 212-20-7114 **Director** 1 □ M 2 🗶 F Aug. 4, 1924 West Virginia Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 Tes 2 No Rising Sun Maryland Cecil 10e. Street and Number 10f. Zip Code 23a or 10g, Citizen of What Country? Funeral 21911 U.S.A. 324 Harrington Road items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. ō 1 Never Married 2 XMarried 1 X Yes If Yes, Give 2 No 72 hours after Completed by Maryland 21215-0036 1 Yes 2 No Specify: 'natural", Year or Dates. 1944-45 Specify: White 3 Widowed 4 Divorced event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aberdeen Proving Ground than Elementary/Secondary (0-12)
Twelve Years College (1-4 or 5+) and Mental Hygiene. is marked other tha Aberdeen, Maryland Accounting Clerk Be 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Virgie Widener Gordon Thomas other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traversone 21078 Leonard Jackson (son) 40 Robinhood Road, Havre de Grace, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Asbury Cemetery 04/26/12 Port Deposit, Maryland 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 Signature of Funeral Service Licenses I Shomas h 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ LUN disease or condition resulting in death) Medical Due to (or a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Box 68760 the ! as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☒ No Day Year Pregnant at time of death ed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy has Yes 2 XNo 2X No 1 Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: No II Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred rector: After 1 atural 5 Pending s after death. 1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 👠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) who completed cause of death (Item 23a) (Type, Print)

State Registrar

5+IVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OLIVIA HOWARD APRIL 27 201°2 5:00 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG CLINTON SOUTHERN MARYLAND HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Hours (Month, Day, Year, Country) 227-36-9300 82 **Director** 1 □ M 2 🛣 F APRIL 6,1930 VA 28a-f shov 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location must be notified at Director CAMP SPRINGS PG MD 1X Yes 2 □ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral US 20748 7102 MURPHY COURT items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ፟ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black White. 9 ģ 1 Never Married 2X Married Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) GOVERNMENT Elementary/Secondary (0-12) SUPERVISOR CLERK 3 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SALLIE THORNHILL permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic a BENJAMIN WHEATON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 7102 MURPHY COURT, CAMP SPRINGS, MD 20748 19a. Informant's Name/Relationship (Type, Print) WILLIAM HOWARD/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5- 10 -2012 CHELTENHAM, MD MD VETERANS CEMETERY 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. M00981 21. Signature of Funeral Service Licensee 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 harles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or Exami The law requires that the death certificate be executed and I-tran that initiated events Due to (or as a conse uence of resulting in death) Last burial physician s the buria Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 roonths?
1 Yes 2 No ρ Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: ျ 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify Date of injury 27. Manner_of Death 28b. Time of 28c. Injury at Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending heral Director: A Μ Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of ٥

State Registrar 30. Name and address of person w

Date filed (Month, Day, Year

MANOJ MATHUR, M.D.

DHMH 17 Rev 06-2011

o completed cause of death (Item 23a) (Type, Print)

1/00

5801 ALLENTOWN RD, #500, SUITLAND, MD 20746

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Amend Items Registrar	State of Mary 23a per dr	land / D • <b>, g927</b>	epartm 05/22	72012	lealth a <b>dhb</b> Jeath	and M	ental Hy	giene	201	0	100	~ /
			Registrar  1. Decedent's Name (First, Middle, Las				10 01 0	Journ		2. Date of De	ath	<del>2</del> U		3. Time of Dear	th th
	Physicia Medic		DORIS	IRENE		HILL				MAY 2	,2012	Year		1:10P	М
	Examin	er	4a. Facility Name (if not institution, give FREDERICK MEMOR)			4b. City, Town, or Location of Death FREDERICK 4c. County of Death FREDERICK									
	Funeral		5. Social Security Number 6. Se		yrs. last birtho		der 1 Year	If Under 2	24 Hrs. Min.	8. Date of Birl	th v Yearl	9. B	irthplac	e (State or For	eign
	Director		220–28–6463 Usual Residence of Decedent	□ M 2 🛣 F	78 _Y	rs.	0 00,0	,,,,,,,,		Jan. 2	5, 193	34 Ma	ry1	and	
	/land f show d at	tor	10a. State 10b. County	100	c. City, Town								10d.	Inside City Lir	nits
	e Man r 28a- notifie	Director	Maryland Montgo	omery	C1	larksb	irg Zip Code						$\perp$	1 🗌 Yes 2 🗓	No
	with th	Funeral	15015 Hyattstown 1	Mill Road		101.	208	371			•	n of What C ited	-		
	death items ner mu		11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S.	13. Was Dec	edent of His	spanic Orig	in? (Spec	ify Yes or No-	14.	. Race - Am Black, Whi		Indian,	
036	e 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.			2 🔀 No			. ,	Spe	ecify: Wh			
5	2 hour "natur	plete	15. Decedent's Ec (Specify only highest gra	's Education 16a. D			Ca. Decedent's Usual Occupation (Give kind of work done during most of working					of Business			
121	ithin 7 iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	- li	fe. DO NOT	ise retired)			3			ery County ic Schools		
Maryland 21215-0036	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Sun				
ryla	should be file and Mental I 7 is marked o raumatic eve	To	John Hammond Grime							Grosh					
	d 2 sho aith an 27 is ir traui		19a. Informant's Name/Relationship (Ty) Tammy Griffith / I		111					Route Numbe				,	
Baltimore,	ge 1 and nt of Heal : If item 3 or other		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆	2	0b. Place of I		lame of		Da	ate		tion - City o		_	
ti m	permit. Page 1: Department of I Important: If it any injury or of		4 Donation 5 Other (Specify	)	Memor	ial Ga	rdens			2012				ryland	
Ba	Depa Impo any i		21. Signature of Francisco License	ee		Rest	and Address naven Catoo	Funer Etin M	al S fount	ervice ain Hw	s, Skl	kot Co ederi	ody ck.	P.A. MD 217	01
H			23a. Part 1. Enter the disease of comp shock, or reart failure. Ist only or	lications that caused the e cause on each line.	death. Do no		·						Ar	proximate terval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>Renal</u>	Failu	10	Acute	Renal	Fai	lure			Or	nset and Death	
	Examiner			Due to (or as a con	isequence of)  ible Co		ive He	art E	ailu	ıre					
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a cor	isequence of)										
	be executed sician and burial-transi	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of)	:							$\vdash$		
09	cate be executed physician and the burial-transit	edical		d											
189	artifical ding ph se as th	/Wec	IF FEMALE:	3c. If yes, outcome of pr	eanancy										
Rox	requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 2 4 Pregnant at time	Fetal death	3 C Ectop 5 Other		/			230	d. Date of d Month	lelivery Da	y Year	
P.O. H	it the d I by the etache	Phys	9 Unknown	9 Unknown	st want state on in	the codesin		on in Don't	_	T					
ა, უ.	The faw requires that the ate has been signed by the page 2 should be detach	d by	Part II. Other significant conditions co	nunbuling to death but no	resulting in	the dilderlyii	g cause give	sii iii raici,						ause of death? ly 4 <b>X</b> Unkn	- 1
Vital Records,	w requ	Completed					181			24a. Was				findings availa	
ř	sician: The ław r s certificate has b director, page 2 s	S								autop perfo 1  Yes	rmed?	death?	,	_	Ü
/Ital	ding Physician; h. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	lospital:	a □ EB/Outs	ationt 0 🗆	Other	ce of Death	`			011 (0	16.5		
0	ng Phy ter this meral o		27. Manner of Death  1   Natural 5 □ Pending	28a. Date of injury (Month, Day, Yea	28b. Tin	ne of	28c. Injury work?	at		ne 5 🗌 Resid 3d. Describe h			ecity)		
ion	ttendii death. stor; Al	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			М	1 🗆 \	Yes 2 🗆 I		0.1			10-		
Division of	al or A s after Il Direc ed in by		4  Homicide determined	building, etc. (Sp	ecify)	i, street, fact	ory, office		2	8f. Location (S City or Tow		mber or H	urai Hoi	ite Number,	
_	To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director After this certifica completely filled in by the funeral director,	Medical	(Check 2 Medical Examin	cian: To the best of my k er: On the basis of examir	nation and/or i	nvestigation,	in my opinior	n, death occ	curred at t	he time, date a	nd place, and	d due to the	e cause(	s) and manner:	stated.
	To the within 2 To the Somple	Ž	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the bes	t of my knowle		ccurred at th 9c. License		and plac		he cause(s) a 29d. Date si				
	, ,		* unteral				MDD	167	750	)	5/2	2/20	12.		
			30. Name and address of person who co	inpleted cause of death		1	21.15	LLLA	17 1.	1001- C	7410	CHI	2	1001	mD
p	Stat	e	31. Date filed (Month, Day, Year)	. Unugar 2. Regi <del>str</del> ar's S		1-5+	cwar	70	V	1624	ITVL	31	, rue	MILLE	
	Registra	r	MAY 2 2 2012	Serve	A. 6	arker									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		or Maryland	•	ificate of L		iu ivieritai	R	eg. No. 20	12   636
Physicia Medical Exami		Decedent's Nam     MARGAI		HARDES!	πV				2. Date of Dea Month	Day Year	3. Time of Death 1656 hrs
				ve street and number		4b	. City, Town, o	r Location of De	May 9, 20 eath	4c. County of De	
				ity Church Road			Charlotte F			Charles	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 455-17-0147 1 M 2 XF 71 Yrs. Figure 1 Year If Under 24Hrs. Months Days Hours Min. SEP.8, 1940  Funder 1 Year If Under 24Hrs. SEP.8, 1940								Fo	Birthplace (State or reign Country) GERMANY
any .		10a. State	10b. County		10c. City, T	own or Location	1			_,	10d. Inside City Limits
and show	5	MD	CHARL	ES	co	BB ISL	AND				1 Yes 2 No
Maryl r 28a-f	Director	10e. Street end Nu					10f. Zip Code		1	0g. Citizen of What C	ountry?
with the Maryland 1s 23a or 28a-f she pe notified at once		14930 I	POTOMAC	RIVER DI		13 14/00 1		20625	( Specify Yes or No	U.S.	
leath w	Funeral		ed 2 Married	Armed Forces			, specify Cuba	in, Mexican, Pu	erto Rican, etc.)	White, etc	nerican Indian, Black, c.
after o		3 Widowed		If Yes, Give Yaar or Dates:		1 Y	es 2 X No	o specify:		Specify:WH	ITE
hours "natur	Completed by	15. Decedent's Ed		nly highest grade cor College (1-4 or		16a. Decedent's during mos		ation (Give kind e. DO NOT use		16b. Kind of Busine	ss/Industry
036 thin 72 ne.	agn.	12	oridary (0-12)	College (1-4 of		DELI C	LERK			GIANT F	OOD
15-00 illed wi Hygie d other		17. Father's Name				<u> </u>			ame (First, Middle, M	Maiden Surname)	<u> </u>
2121 ald be i Mental marke	To Be	WAEHTV  19a. Informant's Na	VEISTER	and the second second	-	19b Mailing A	ddress (Stre		SCHMID'		ate, Zip Code) 20625
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.				ESTY/SPOU	JSE					COBB IS	
s 1 and of Heal		20a. Method of Dis		Removal from St		ace of Disposition	n (Name of ce		AY ^{Date}	20c. Location - City	
Limo Page ment c		4 Donation 5	Other Specify	:	MET	RO. CR			6,2012	ALEXAND	RIA, VA
Balti permit. Departm Importa		21 Signature of Fu	neral Service Licer	Set	M006	22. Nan 41   563	ne and Addres 5 WASI	s of Facility R.	AYMOND IN AVE.,	FUNL. SEI LA PLATA	RVICE, P.A. , MD 20646
Physician /Medical		23a. Part I. Enter the failure. List on	ne disease, or comp ly one cause on e	plications that caused ach line.	the death. D	o not enter the	mode of dying	, such as cardia	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause ( or condition resulting		Multiple Injuries  Due to (or as a conse							Death
54 _ ,		Sequentially list co	nditions, b.					<u>.</u>			
	nine	if any, leading to in cause. Enter Under	erlying Cause	Due to (or as a conse	equence of):						
ed sit	Examine	(Disease or frijury to events resulting in	death) Last	Due to (or as a conse	equence of):						
Vital Records, P.O. Box 68760, sricina: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED	d.	AMENDED							
'60, ate be	S S	IF FEMALE:	50/2 . 50	23c. If yes, outcor	ne of pregna	ncy				23d. Date of deliv	ery
certific	jan/	23b. Was decedent past 12 months		1 Live birth  4 Pregnant at	time of death	<u> </u>	death 3	Ectopic pre	gnancy	Month	Day Year
Box death the atte	Physician/	1 Yes 2 N	No 9 🗹 Unknown			n 5 Other	(Specify)				
that the	by P	Part ii. Other signi	ficant conditions	contributing to death	but not resu	ulting in the und	erlying cause	given in Part I.			to the cause of death?
ds, F		-					-		_ 24a. Was a		robably 4 Unknown autopsy findings available
e law re	Completed								_ autop:	sy prior t med? death	o completion of cause of ?
il Re in: Th rifficat for, pag		25. Was case refer	red to medical	<u> </u>			26.Place	of Death (Che	1 Yes 2	2 No 1 🗸	Yes 2 No
Vita	To Be	examiner? 1 ✓ Yes	2 No	lospital: 1 Inpatie	nt 2 E	R/Outpatient 3	DOA	Other Nur	rsing Home 5	Residence 6 🗸 Ott	ner: Scene
ion of tending Pheath.	Certification:	27. Manner of Deatl  1 Natural	5 Pending	28a. Date of Inju	ear) F	8b. Time of Inju		ıryat Work? Yes 2 ✔ No	28d. Describe h Driver auto f	now injury occurred fixed object collis	sion
Division pital or Atto ours after de ceral Directo filled in by t	ifica	2 Accident 3 Suicide	Investigati  6 Could not	28e Place of In		l646 hrs e, farm, street, f	actory, office b	ouilding, etc.	28f. Location (S	Street and Number or	Rural Route Number, City
Di spital hours a neeral )	3	4 Homicide	determine	(Opecary) Loc							rch Road, Charlotte Hall
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Palca	one) 2	Medicai Examine	<ul><li>an: To the best of my</li><li>On the basis of exar</li><li>and manner stated.</li></ul>	knowledge, nination and	, death occurred for investigation	et the time, da , in my opinion	ate and place, a n, death occurre	and due to the cause ed at the time, date a	e(s) and manner as st and place, end due to	ated. the cause(s)
6 4 5 4 9	ž	29b. Signature and	title of certifier				29c, Licens			29d. Date signed (A	fonth, Day, Year)
13 m		unlo					0.C.	M.E.		May 10, 2012	
131		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
Sta Registi	_	31. Date filed (Mont	h, Day, Year)	32. Registra	's Signature	Kel					

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AMEND TIEM#23a, Pt II per PHYS, G937, 37 47 2013, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 16365 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year 10, 4:15AM WAYNE L. HOPPE Мау Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Pylesville 2115 Harkins Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-48-1135 Hours 10/22/1947 Maryland Director 1**X** M 2 □ F 64 Usual Residence of Deced 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified Pylesville MD Harford 1 Yes 2 X No or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 2115 Harkins Road 21132 permit, Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must I 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White If Yes, Give1s966-69 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Tree Farmer Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary McMaster 17. Father's Name (First, Middle, Last) Cletus D. Hoppe 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Harkins Road, Pylesville, MD 21132 Linda Hoppe/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other p 5/14/2012 Evans Eagle Cr. Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Harkins Funeral Home, Inc., De $^{173,14}_{
m PA}$ PA 23a. Part 1. Enter the disease or complications that caushock, or heart failure. List only one cause on each or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown þ Part II. Other significant conditions constituting to death but not resulting in the underlying cause given in Part I.

ISCHEMIC HEALT DISEASE 23e. Did tobacco use contribute to the cause of death? <u>`</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe or Attending Physician: The 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes examiner?
1 Yes 2 No
27. Manner of Death ျှ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY State NAY 2 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 28^{Day} Physician/ Carol Virginia Jones 201^{Yes} 2145 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **E**xaminer Calvert Manor Health Care Center Cecil Rising Sun 8. Date of Birth (Month, Day, Y Nov. 20, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X Hours Year 1936 West Virginia 236-54-6719 75 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 21911 53 North Hills Drive U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married illed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify: White "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Acme Market other than Elementary/Seconday (0-12) College (1-4 or 5+) the Rising Sun, Maryland Twelve Years Cashier traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H item 27 is marked o ည Lovelia M. Stanley Joseph Harold Belcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathie J. White (Daughter) 123 Sunrise Drive, Rising Sun, Maryland item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. cemetery, crematory or other place West Nottingham 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 05/03/12 Colora, Maryland 4 Donation 5 Other (Specify) Cemetery Signature of Funeral Service Lice 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CNGESTIVE Cardiomyon Many Year disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** NONARY Heave Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 W No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? willation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗆 No 1 Yes the Hospital or Attending Physician: I hin 24 hours after death.
the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation the 6 Could not be Suicide within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MN LATTIW 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Johnson Dertina 3.30AM. Spr. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Denton Caroline If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) Nary and Months Days Hours (Month, Day, Year, 214-32-145 | Usual Residence of Decedent Director Dec: 21, 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at 10b. County Director "natural", or items 23a or 28a-f sl dical Examiner must be notified MID 1 X Yes 2 No avoline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 21215-0036 hours after Black If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 → Widowed 4 □ Divorced and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Crab Picker 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed beatment of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Cornis rnest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kegina 54. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Cambridge, MD 5/5/2012 22. Name and Address of Facility Henry Home P.A. Funeral 21. Signature of Funeral Service Licensee C. 510 Washington ambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ PULLONARY HYPERTENCION disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed CONGESTIVE Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical MABBIES Box 68760 the as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death per signed by the P.O. be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed this certificate 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{R}\) Residence 6 \(\sum \) Other (Specify) 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: After 1 28c. Injury at 1. Natural 5 Pending work?
1 Yes 2 No Accident Investigation thin 24 hours after death the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier 1. Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DAFFIN LN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

171)

609

62. Registrar's Signature

LACET.

JAMES LA
31. Date filed (Month, Day, Year)

12-03697 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Elizabeth Jurney State of Maryland / Department of Health and Mental Hygiene 2012 16368 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 14, 2012 **Medical Examiner** 1608 hrs Elizabeth H. Jurney 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4025 Howes Court 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours (unk) Director 577-20-2387 1 M 2 X F 03/04/1922 90 Usual Residence of Decedent 10a State Oc. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No s 23a or 28a-f show e notified at once. or 28a-f show Dunkirk Calvert es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20754 United States 4025 Howes Court 11. Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 2 X No Yes 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) (unk) event, the Medical Itimore, MD 21215-0036 (unk) (unk) 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Virginia F. O'Brien Harry W. Harbin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (unk) Donald Rayle / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State (unk) t: If it crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Suitland, MD Cedar Hill Cemetery 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert. EARY 21. GOE 8200 Jennifer Lane, Owings, MD 20736 23a. Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Positional Asphyxia complicating Atherosclerotic Between Onset and /Medical Death Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions If any, leading to immediate Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me,  $g_{928}$  6-1-12 sm attending physician for use as the burial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death Natural Pending 1 Yes 2 X No death. Director: subject fell 2 X Accident 5-14-12 fd 03:40 am Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State 4025 Howes Ct. determined To the Funeral Found: Residence Homicide Dunkirk.MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 241 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registra

DHMH 17 Rev 1/2001

**OCME 2006** 

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. R gistrar's Signature

29c. License number O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

May 15, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Medical **Examiner** Town, or Location of Death 4c. County of Death Glen Bumite Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Director 213-76-6594 1959 MARYLAND 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director must be notified MARYLAND ANNE ARUNDEL SEVERN 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1704 MEADE VILLAGE CIRCLE 21144 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or ite Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than ' Elementary/Secondary (0-12) College (1-4 or 5+) CHILD CARE PROVIDER CHILD CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever မ LOUIS MCGOWAN SR NAOMI JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other trau DEIRDRE MCGOWAN/DAUGHTER 1704 MEADE VILLAGE CIRCLE SEVERN MD 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State BESTGATE MEMORIAL PARK Department Important: It any injury or once. 5/10/2012 ANNAPOLIS, MD
STING TRIBUTES BY FELLOWS
CREMATION & FUNERAL CARE
ANNAPOLIS, MD 21401 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22. Name and Address of FacilityLA HELFENBEIN & NEWNAI 814 BESTGATE ROAD 23a. Par . Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List inly one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 L Fetal uses.
Pregnant at time of death 3 Cther (specify) in the past 12 months?

1 Yes 2 No signed by the at the detached f P.O. signed 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? this certificate 2 No Yes 1 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death. To the Funeral Director. After 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injury work? 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 20057006 KO HO ess of person who completed cause of death (Item 23a) (Type, Print

State Registrar Lelin Chas MD

31. Date filed (Month, Day,

Saltimore 40 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min. **Director** 003-28-2321 1**X**□ M 2 □ F 72 08/05/1939 Washington DC "natural", or items 23a or 28a-f show edical Examiner must be notified at ould be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20716 1424 Perrell Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give 77: Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 X Divorced Year or Dates. Vietnam Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, College (1,04 or 5+) Elementary/Secondary (0-12) other traumatic event, the Business Owner Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H 7 is marked ot 0 George Julian Lois Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s Health s tem 27 i Michael Julian Son 1424 Perrell Lane Bowie, MD 20716 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 05/04/2012 Glen Burnie, MD 22. Name and Address of Facility
Hardesty Funeral Home P.A. 12 Ridgely Ave Annapolis, MD 21401 21. Signature of Pun ervice Licenses Sai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a c cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed this certificate h 2 🗌 No 1 Yes 25. Was case referred to medica examiner? director, Be 26. Place of Death (Check only one) Hospital Other: 2 100 1 Tyes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) MANUL 1 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendit within 24 hours after death. To the Funeral Director, Af completely filled in by the ft. 1 Yes 2 No М Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. May 4,2012 30. Name and address of person noleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald King Jones May 2012 5:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Envoy of Denton Denton Caroline If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 218-26-2515 1 M 2 - F **Director** 5/10/1933 78 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Caroline Greensboro 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11937 Kibler Road 21639 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items may injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married X Yes 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Year or Dates. 52-56 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lineman Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Jones Jane Louise King 19a. Informant's Name/Relationship (Type, Print) Cara Avery - Daughter 30 Seward Road, Ridgely, MD 21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem Gardens 5/9/2012 4 Donation 5 Other (Specify) Annapolis, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Month! Physician/ ARGE CELL LINAPLASTIL disease or condition Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Die to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day ed by the at detached f 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS, HYPKTEUSION, CHRONIC 1 Yes 2 No 3 Probably 4 Unknown PENAL INSUFFICIENCY, HYDRIALLEMIA Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy 1 Yes 2 No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Safter dea... ral Director: After u... "vv the funeral di After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral I Medical

State

within 24 hou

To the Funer

completely file

29a. Certifier

(Check only one

Registrar DHMH 17 Rev 06-2011 🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00530

321 BLOOMINGDALE AUE FERRALS BURG, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Catherine Jenkins May 22:24 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG Southern MD Hospital Clinton Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 577-86-9975 Director 1 🗆 M 2 🗶 F 02-27-1959 Wash. DC 53 Yrs. Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD PG Oxon Hill Y Yes 2 No 10f. Zip Code **20745** 10e. Street and Number 10g. Citizen of What Country? USA 510 Barrymore Dr. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private 10 Home Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mae Washington Arthur Teo Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 510 Barrymore Dr. Oxon Hill, MD 20745 Swanzetta McCoy-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other 1X Burial 2 Cremation 3 Removal from State Heritage Memorial Pk 5-12-2012 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) M01426 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service Lice Kond 10583 Middleport Ln. White Plains, MD 20695 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or profestive 4/416 Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Dronge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician To Be Completed by Physician/Medical P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral D the Hospital 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011 06-06-2012

Holl Rd, 507, Oxon Holl, MD 20745

SOKONEWO, MD

MAY 0 8 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print) SYEVESTER OLONICWO . 6192 0000

Tracy Beth Vander Kolk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 16373

		Registrar		Ce	ertificate o	t Death			Reg. No.		
Physic Medical Exam		Decedent's Name (First, Midd Tracy Bet	h Vande	r Kolk				2. Date of D Month May 11	Day Yea	or .	Time of Death 0001 hrs
		4a. Facility Name (if not institution Baltimore Washington				4b. City, Town, o Glen Burni		ath	4c. County Anne Ar		
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$							Birth(MM/DD/YYYY 0/1996	n(MM/DD/YYYY) 9. Birthplace (State or Foreign IOWa Country)	
nd show any ice.	_	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arundel		y, Town or Loca						od. Inside City Limits  Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country	?
with the ns 23a o	ral D	546 Charingto	12. Was De	cedent Ever in U		21146 as Decedent of H	ispanic Origin? (				Indian, Black,
after	by Funera	3 Widowed 4 Div	larried Armed F 1 Yes vorced If Yes, Give Ye or Dates:	2 X No ar	1	Yes, specify Cuba	o s <i>pecify:</i>				ce
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 10		1-4 or 5+)	during n	nt's Usual Occupa nost of working life cudent			16b. Kind of Bu Hiah	siness/Indu	·
ID 21215-0036 : should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Com	17. Father's Name (First, Middle Keith Vander						me (First, Middl Vander	e, Maiden Surname		
2121: hould be fil nd Mental I is marked	10 E	19a. Informant's Name/Relations			19b. Mailin	g Address (Stre			Notice lumber, City or Tow	n, State, Ziş	Code)
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental lant: If iten 27 is marked or other traumatic event,		Keith Vander 20a. Method of Disposition			Place of Dispos	sition (Name of ce	emetery,	Date	erna Park		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		1 X Burial 2 Cremation 4 Donation 5 Other S 21 atur of Funeral Service	pecify:	rom State Ou		of the I	ery	lay 15, 2012	Miller		•
		John Ch	Dann		43	2 KILLI	Le nwy,	⊅E	everna Par	K, ML	
Physician		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.		n. Do not enter t	the mode of dying	, such as cardiad	c or respiratory	arrest, shock, or hea		Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)		a consequence o	of):						
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		a consequence o	of):						
cecuted n and - transit	Exa	events resulting in death) Last	d.	a consequence o	,						
। ज्ञान	n/Medical	IF FEMALE:				er me,g9	27 5 <del>-</del> 29-	-12 sm	001 D.1(		
		23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✔ Uni	1 Live t	nant at time of de	2 F6	etal death 3 ther (Specify)	Ectopic preg	nancy	23d. Date of Month	Day	Year
P.O. Bc that the der ned by the a	Physicia	Part II. Other significant condit	Ja Chiki		resulting in the I	underlying cause	given in Part I.	23e. Dio	d tobacco use contri	bute to the	cause of death?
s, P.O. ires that the signed by d be detack	d by							1 🗆 \	/es 2 ✔ No 3	Probably	y 4 Unknown
of Vital Records, ng Physician: The law require stifter this certificate has been si nneral director, page 2 should b	Completed				-		<u></u>		topsy p rform <u>ed</u> ? d		sy findings available bletion of cause of
tal Re	Be C	25. Was case referred to medica				26.Place	e of Death (Chec			V 100	
F Vit Physici r this c	P	examiner? 1 Yes 2 No		Inpatient 2					Residence 6		
ion of ttending P leath. tor: After / the funera		27. Manner of Death  1 Natural 5 Pend 2 Accident Invest		of Injury n, Day,Year) -10-12	28b. Time of I		ury at Work? Yes 2. ██ No		e how injury occurrent hanged		
Division pital or Attendii ours after death. teral Director: A	Certification:	4 Homicide deter	d not be rmined (Specify)		Reside	et, factory, office	building, etc.	or Town	(Street and Number , State) <b>546 Ch</b> na Park, M	naring	Route Number, City
Division of Vital Records, P.O. Box 6 within 24 blossible death certain 24 bloss after death. The law requires that the death certwin 24 bloss after death. The law requires that the death cert of the Funcral Director. After this certificate has been signed by the attendit completely filled in by the funcral director, page 2 should be detached for use	Medical (		hysician: To the bes miner:On the basis and manner s	of examination a							iuse(s)
	Ĭ	29b. Signature and title of certifie		1/1		29c. Licens			29d. Date signe May 12, 20		Day, Year)
(2)		Name and address of person Russell Alexander MD	•	se o dea (Item Medical Exan		W. Baltimore	Street, Balti	imore, MD 2	21223		
Sí Regis	tate trar	31. Date filed (Month, Pay, Year)	32. R	gistrar's Signati	ure d.	ald					
DUMUL 47 D 4 /0	004							UUME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Keu Day Physician/ Year Month 9:35 AM ,72 -/TL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town or Location of Death 4c. County of Death Birthplace (State or Foreign Country) If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 💢 M 2 🗆 F Days Min (Month, Day, 69 Yrs 179-32-4270 Director Sept.30.1942 <u>Pennsylvania</u> Usual Residence of Decedent 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Millersville MD Anne Arundel 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 390 Boxelder Court 21108 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, 1962 Black, White, etc. Armed Forces
1 X Yes 2
If Yes, Give
Year or Dates þ 1 Never Married 2 X Married 2 No Maryland 21215-0036 1966 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Seconday (0-12) College (1-4 or 5+) Agency Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bertha Wilcox John Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 390 Boxelder Court Millersville, MD 21108 Kathryn Kelly / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If its any injury or of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 07,2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemtery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease shock, or heart falure. Li or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, If only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ TASTATIO disease or condition 375 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, ner Due to forms a nonsectional off if any leading to immediate cause. Enter Underlying Exami burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? this certificate 1 Yes Yes sompleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? HOS PIL Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death s after death. I **Director**: After th 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) E D 003658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eva Hersh, M.D. 445 Defense Highway Annapolis, MD 21401 31. Date filed (Month, Day, Year State 4 2012 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 2012 Juliana L. Keller 13:21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 57 Yrs **Director** 218-66-4632 1 🗆 M 2 🕱 F 10/22/1954 Virginia Usual Residence of Deced ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Edgewater Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21037 1809 Longwood Road death \ 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Yes, Give Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) event, the Giant Food F1orist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles William Holliday June Margaret Haymaker other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a James Keller/ Husband 1809 Longwood Road, Edgewater, Maryland 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 5-4-2012 Edgewater, Maryland 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examir Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) for Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Pregnant at time of death Month Dav Year the 9 Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: _2 💢 No 1 🗋 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) 24 hours Medical 29a. Certifier 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) of certifie 29b. Signature and Jitts 29c. License number 29d. Date signed (Month, Day, Year) RES-000 May 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, Maryland 21224 Brian Hwang 31. Date filed (Month, Day, Year) State MAY 04 2012 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 201^{Yea} Michael Anthony Kennedy 7:02 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-78-6315 Director 1 🔀 M 2 🗆 F 53 5/19/1958 Washington DC Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Worcester Ocean City 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be I 2811 Plover Dr., Unit 107 21842 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, William J. Kennedy, Sr. Frances H. Rooney 19a. Informant's Name/Relationship (Type, Print) brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Kennedy, Jr. 7317 Cabin Cove Rd., Sherwood, MD 21665 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State First State Crem. 5/9/2012 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine r as a consequence of): If any leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 $\square$ Nursing Home 5 $\square$ Residence 6 $\square$ Other (Specify) of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Burkin 977 2 Hon 133

State Registrar Date filed (Month)

2012

5

61-

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygiene
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. No. 2 5 3 1
	Physicia		Helen Lucille Kay		2. Date of Death Month 5 Day 2012 8:58 PM
	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	,		Hartley Hall	Pocomoke City	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country)
	Director		231-18-1186   1 LXKM 2 L F   89 Yrs.	Montale Baye Hours Will.	(Month, Day, Year) 11/5/1922 Country) VA
	and show	Ď	10a. State 10b. County 10c. City, Town or Lo	peation	10d. Inside City Limits
	Maryla Ba-f	rect	MD Worcester Pocomo	ke City	1 ☐ Yes 2 🙀 No
	the l	٥	10e, Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h with	Funeral Director	1006 Market Street	21851	USA
	r item	/ Fu	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	al", o	d b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐XNo Specify:	Specific
ŏ	hours natur fical I	Completed by	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business Industry
2	in 72 e. nan "	duc	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of worki O NOT use retired)	ng Table and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the s
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Maryland 21215-0036	ntal H red of	To B	17. Father's Name (First, Middle, Last)	1	e (First, Middle, Maiden Surname)
Ž	ould by Me Me mark		Romeo Hasell Burton  19a. Informant's Name/Relationship (Type, Print)  19b. Maili		n Godsey
Š	and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		100.11		Route Number, City or Town, State, Zip Code) Lane, Charlotte, NC 28278
re,	ge 1 and 2 should be it of Health and Men it item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Dispo	osition (Name of	Date 20c. Location - City or Town, State
Ē	Pag Jan Ta		2 Dana 2 - Ordination o - Homovar nom otate	matory or other place) Mem. Park 5/9/	/2012 Berlin, MD
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Function Service Licenses 22	2. Name and Address of Facility Bur	cbage Funeral Home
_	9 0 E 8 9		1 Mille Stulate 1	08 William St.,	, Berlin, MD 21811
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause in yach line.	1 10	Interval Between
~~~~	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Athero seler	Onset and Death
	Examiner		Due to (or as a consequant of):		
		ner	Sequentially list conditions, b. Sue to or as a consequence of		
	uted id ansit	ami	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.		
	be executed sician and burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):		
09	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		d		
687	ertifica ding p	Physician/Me	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy		
Rox	death o	ciar	in the past 12 months? 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
В	the de	hysi	9 Unknown		
О	that the lined by the detach	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ds,	quires en sig ould b	ted	Is chery's Caroningo pay	my #- Fib.	1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	Physician: The law requires this certificate has been sign ral director, page 2 should be	Completed	<u> </u>		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
Ř	The I	Col			performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
ta	ician certifi ector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check	
01	ding Physician. The law h. Affer this certificate has funeral director, page 2 &	١٩	1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 LJ DCA 4 LJ Nursing Hor	ne 5 Residence 6 Other (Specify)
n C	nding ath. :: Afte e fune	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) injury 2 ☐ Accident Investigation	work? M 1 \(\superset \text{Yes} 2 \superset \text{No} \)	ied. Describe now injury occurred
DIVISION	er dez	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Street and Number or Rural Route Number,
2	ital or Irs aft al Dir	<u> Ö</u>			City or Town, State)
	Hosp 24 hou Fune sted fil	edical	29a. Certifier 1 V Certifying Physician: To the best of my knowledge, death of Check 2 Medical Examiner: On the basis of examination and/or investigation.	tigation, in my opinion, death occurred at t	the time date and place, and due to the cause(s) and manner stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funeral Director.	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, on 29b. Signature and vitte of certifier	death occurred at the time, date and place 29c. License number	e, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
	⊢ s ⊨ ő		1 (SARAD R. BARAL, MI)	0) 0544.99	5-5-20/2
		ł		Print)	
	ET	5	1604 Merket St., Pozoni	ske MJ	2/851
	Stat Registra	٠	31. Date filed (Month, Day, Year) A Y 0 8 2012 32. Jegistrar's Signature	arked	
	negistra	1	MILL OF THE PROPERTY OF THE PR		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Mau 2:00 a.M Leo Kopit 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Harmony Hall Retirement Community Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8 Date of Rirth Days (Month, Day, Year) 578-14-8890 **Director** 1 🛛 M 2 🗆 F 94 08/18/1917 Rhode Island 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia 1 Yes 2 X No Maryland Howard 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral U.S.A. 6336 Cedar Lane, #380A 21044 12. Was Decedent Ever in U.S. Armed Forces?

1 🔯 Yes 2 🗌 No 1941 – If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced White 1945 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked c and ...
of Health an...
frem 27 is marn...
r traumatic ev ပ Sophie Kessler Joseph Kopit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9630 West Window Way, Columbia, Maryland 21046 Rita J. Brill - Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or ot once, Page 1 1 X Burial 2 Cremation 3 X Removal from State King David Mem Grans 05/07/2012 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. |11800 New Hampshire Ave., Silver Spring, MD 20904 23 art 1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart frours. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fire I Physician/ disease or condition resulting in death) Vascular Disease Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-trapel and that initiated events Due to (or as a consequence of): resulting in death) Last physician s the buriat Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Hospital: 욛 1 Yes 2 🗶 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending Within 24 hours after death.
To the Funeral Director: After 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6+1 May 03, 2012 D47747 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris, M.D., 6334 Cedar Lane, #103, Columbia, Maryland 21044

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

MAY 07

2012

Box 68760

P.O.

Records,

Division of Vital

onathon D. Kinard State of Maryland / Department of Health and Mental Hygiene										
		1- For State Certificate of Death Registrar		g. No. 201	2 1637					
Physicia Medical Exami		Decedent's Name (First, Middle,Last)	2. Date of Deat Month May 13, 20	h	3. Time of Death 0525 hrs					
VIEUICAI EXAIIII	Her	Johnathon Darrell Kinard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		J12 4c. County of Death						
1		4315 Ridgeway Terrace Prince Frederick		Calvert						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		h (MM/DD/YYYY) 9. Birt Foreig	hplace (State or					
Director		212-11-5142 1XM 2 F 27 Yrs. World 03/17/1985 Country								
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
. ₫					1 Yes 2 X No					
Aaryland 28a-f show 1 at once.	Director	MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code	10	ng. Citizen of What Cour	itry?					
ith the Maryland 23a or 28a-f sho notified at once.	Dire	2560 Cecil Lane 20639		United Sta	tes					
with ms 23.	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Ameri	can Indian, Black,					
or items	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	rican, etc.)	White, etc.						
s after	Ş	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business/Industry							
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		TOD. Raid of Business/ii	iddaily					
036 ithin 7 ne.	Jdu	9 Mechanic		Automobil	e					
5-0 iled w Hygie the N		17. Father's Name (First, Middle, Last) 18. Mother's Name		laiden Surname)						
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu c event, the Medical Exan	Be	Randal Rice Lesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Venis	has City as Town Chata	Zin Codo)					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	2	Melissa Kinard / Wife 4315 Ridgeway Terrace								
e, N I and 3 Health item 3		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or						
Baltimore, permit. Pages 1 an Department of He Important: If ite	П	1 Nation 2 Cremation 3 Removal from State crematory or other place) 4 Denation 5 Other Specify: Trinity Memorial Gardens 05/3	18/2012	Waldorf, M	TD					
altir mit. } partme		21. Signature of Fundral Service Licensee 22. Name and Address of Facility Lee								
		Amanda M. Ergler 8200 Jennifer La	ne, Owin	ngs, MD 207	36					
Physician / / / / / / / / / / / / / / / / / / /		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and					
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a Oxycodone Intoxication Due to (or as a consequence of):			Death					
* *		Sequentially list conditions, b								
	iner	if any, leading to immediate Due to (or as a consequence of):								
, ii	Exam	(Dissass or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
e executed cian and rial - transit		■ MyENDED 23a, 27, 28a-f, per me, g928 6-1-1	2 ст							
6 be es ysiciar burial	Physician/Medical	#4a, per me, g920 0-0-12 sm		22d Date of deliver						
rtificat ing ph as the	<u>₹</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delivery Month D	ay Year					
lox 68760, leath certificate be attending physici for use as the buri	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown								
that the dended by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use contribute to 1	he cause of death?					
	d b		1 Yes	2 No 3 Prob	ably 4 🗹 Unknown					
aw requir	Completed		. 24a. Was a		opsy findings available ompletion of cause of					
eco he law ate has	틹		perform	med? death?						
Vital Rec ysician: The I this certificate I director, page	BeC	25. Was case referred to medical 26.Place of Death (Check	only one)							
bysic at dire		1 V 1es 2 100		Residence 6 🗸 Other	Scene					
ion of tending Pheath. tor: After the funeral	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 Yes 2 X No	unknown	ow injury occurred						
iSiO	icat	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	treet and Number or Ru	al Route Number, City					
Div	Certification:	Suicide 4 Homicide Gould not be determined (Specify) Residence	or Town, St	ate)4315 Ridge Frederick,M	way Terrace					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	I due to the cause	e(s) and manner as state	d.					
To the Youthin To the complex	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date a	/						
	≥	29b. Signature and title of certifier 29c. License number O.C.M.E.	i velt	29d. Date signed (Mon May 13, 2012	ın, ∪ay, rear)					
	ļ	30. Name and address of person who completed ca(s) of death (Item 23a)	ne.							
		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, B	altimore, MD	21223						
		31. Date filed (Month, Day, Year) 32. Registrar's Signature f. Sauck								
Regist	1	WEBST B C / 111/ (MARCON) . July 100			1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 4, 201°2 Aubrey Leroy King 11:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6475 Long Beach Drive St. Leonard Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Days 64 08/2471947 Washington, D.C. **Director** 216-50-7552 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Calvert 1 🗆 Yes 2 💢 No Maryland St. Leonard 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 6475 Long Beach Drive 20685 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces: Black, White, etc. 1 Never Married 2 X Married ρ 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pressman Printing Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Doris Lorraine Satterfield Aubrey Alvin King other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other. 6475 Long Beach Drive St. Leonard, Maryland 20685 Holly Barnes 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/18/2012 Maryland Veteran Cemetery Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONI disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examil or Attending Physician: The law requires that the death certificate be executed -tran Due to (or as a consequence of) resulting in death) Last inding physician a use as the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? jo Day Year Pregnant at time of death signed by the a d be detached f 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 24 hours after death Funeral Director: A 2 No filled in by the Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 🗌 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check Certifying Nurse Practionart To the best of my knowledge within 7 29b. Signature and title of certifier 29c. License numbe

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- Q 2017 \

32. Registra s Signature

Kenneth Sanchez Villar, MD

31. Date filed (Month, Day, Near)

D67495

14090 H.G. Trueman Road, Suite 2100, Solomons, Maryland 20688

29d. Date signed (Month, Day, Year)

May 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MA Medical 4a. Facility Name (if not institution, give street and numb Examiner or Location of Death Lubia If Under 1 Year If Under 24 Hrs. 6. Sex. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 010-36-5553 Director 1 🗙 M 2 🗆 F IL 65 Yrs 02/01/1947 Usual Residence of Deced th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Glenwood 1 Yes 2XX No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3673 Sharp Rd. 21738 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

**XXYes 2 \sum No Vietnam Black, White, etc þ 1 Never Married 2 XX arried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: White Specify 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Merchant Auto Recycling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment.
Important: If item 27 is marked any injury or act. Percy Raymond Kendall Jean Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 3673 Sharp RD. Glenwood, MD 21738 Valerie Kendall Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial ※X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Atlantic Crematory 5/12/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licens 22. Name and Address of Facility Hardesty Funeral Home, P.A. once, at Ridgely Ave. Annapolis, Md 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death WOON Physician/ Atherosalvohi disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on, Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): nding physiciar Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) atter in the past 12 months?

1 Yes 2 No Ectopic pregnancy for Month Day Year Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 2 🗌 No Investigation Accident rpletely filled in by the 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signati ure and title of 29d. Date signed (Month, Day, Year,

Registrar

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State

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person who completed cause of death (Item 23a) (Type, Prin

0 8 2012

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		For		State o	f Mary	/lanc					and M	1ental Hy	gien	е			
		- State Registrar	/E' 14'-14'-	1			Cer	tificate o	of D	eath			Reg. N	10. 2		<u>, </u>	638
Physiciar Medic		1. Decedent's Name Mary	e (First, Middle,	Lasty	•			Ke	eeh	an.		2. Date of De May 4		^{0a} /2012	Year		e of Death
Examine		4a. Facility Name (if							of Death	4c. County of Death Anne Arunde							
Francis		Heritage 5. Social Security Nu		ır Health			st birthday)	Anna If Under 1		L1S If Under	24 Hrs.	8. Date of Bir	rth	Anne			te or Foreign
Funeral Director		577-16-3	847	1 □ M 2 😾 F		92	Yrs.		ays	Hours	Min.	(Month, Da 11/03/	r) Country)				
T MO		Usual Residence o	of Decedent 10b. County		10c. City, Town or Location					11/03/	171.				e City Limits		
aryland a-f sh fied a	ا <u>ټو</u>	MD	,	rundel			rchtor										Yes 2 X No
or 28		10e. Street and Num	nber					10f. Zip Co	ode				10g. (Citizen of V	Vhat Cou		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	5621 Car	rroll S	treet				207	733					U	SA		
death item ner m	ᆵ	11. Marital Status		12. Was Dece Armed For 1 \(\sum \) Yes	dent Ever	in U.S.	13. V	Vas Decedent Yes, specify	of His Cubar	spa <i>n</i> ic Ori	gin? (Spe ı, Puerto	cify Yes or No- Rican, etc.)	-	1	e - Amerio k, White,	can Indian	,
al", or	d by	1 Never Marri 3 X Widowed		ed 1 Tes If Yes, Give Year or Da	e		1	☐ Yes 2 🛚	No	Specify:				Specify:		ite	
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be file ental l ked o ic eve	卢	Joseph	Zanelo							Lena		zzocch:		n Surname	7)		
hould and Mi s mar	Ì	19a. Informant's Na			-		19b. Mailir	g Address (St	treet a		-	l Route Numbe		or Town, S	tate, Zip (Code)	
ealth a m 27 i		Lenamar		y Daught	er		5621	Carrol	1 9	Stree	t Ch	urchto	n,MI	207	33		
t of Har of Hitel		20a. Method of Disp 1 Burial 2		3 Removal from	State	cer	metery, cren	sitio <i>n (Name c</i> natory or othe	r place			Date	20c.	Location -	City or To	own, State	•
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permi Depar Impor any ir		21. Signature of Fur	rejal Service Li				H	ardest	y F	uner	al H	ome P.A	. A	nnapo	ligery Slis,	MD ^V 2	1401
				complications that c nly one cause on ea		P		/	f dying	, such as	cardiac c	or respiratory a	rrest,				Between
Physician/		Immediate Cause (fi		_ a		<u>a</u>	reclu	re to	my	f then	UC.					Onset a	nd Death
Medical Examiner		resulting in death)	- 4	Due to (or as a co	nseque	ence of):										
	Jer	Sequentially list con	nditions, imediate	b. Due to (or as a co	nseque	ence of):								+		
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al or A s after I Direct	Se	4 Homicide	determi		ng, etc. (S _I		io, iaiii, oci	, , , , , , , , , , , , , , , , , , , ,				City or To			,, 0, 110,0	710010740	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical Certificate:			Physician: To the be caminer: On the basi													manner stated
the Fithin 2 the Formplet	ğ		☐ Certifying	Nurse Practitioner:				death occurre	ed at th				the cau		nanner as	stated.	
5 2 5 8)						D	5	107	8		W	M	7,2	0/)
9,5		30. Name and addre	ess of person w	ho completed caus	e of death	(Item 2	23a) (Type, P	rint) A10	, (To o	121.	annin	Y/r	m	() (7/LV	1/
State	.	31. Date filed (Month	h, Day, Year)	112 22. Re	egistrar's S	Signatu	ire V	OUT		160	5/1	muy	1()	W/ (1	10	1/	/
Registra	r	1775	1 0020	16 Clerk	w	A.	Mar	Kil									

DHMH 17 Rev 06-2011

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20<u>12</u> Month Physician/ 10:53 ам Marie Kane May 3, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery 4b. City, Town, or Location of Death Examiner Bethesda 9818 Belhaven Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) 577-32-5915 Director 1 □ M 2 🖰 F 84 9, 1928 Washington, DC Feb. permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "natural", or items 23a or 28a-f shown any hjury or other traumatic event, the Medical Examiner must be profitted at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🖾 No Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 USA 9818 Belhaven Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Š SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cyrilla Barbara Thiel George Bernard Donohue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9818 Belhaven Road, Bethesda, MD 20817 William A. Kane, Jr./Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MayDate 7, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2012 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francisco Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 MO1503 oseph 1. Rad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Ischemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and I for use as the buriation Exam Hospital or Attending Physician: The lew requires that the death certificete be executed Atherosclerosis Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Exacerbated Chronic Obstructive Lung Disease, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Metastatic Carcinoma, Non-Small Cell Lung Cancer 24a. Was an performed? 1 ☐ Yes 2 ♣ No 1 ☐ Yes 2 ☐ No certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 2 🖾 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Natural 5 Dending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

lC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

Irving Mizus, MD
31. Date filed (Month, Day, Year)

MAY 04

D26571

10605 Concord Street, Kensington, MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Matthew Keel Jr. 1656 May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days (Month, Day, Year) Hours Min Director 238-58-8511 1 🖾 M 2 🗆 F Sept. 10, 1936 North Carolina 75 Usual Residence of Decede or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rector 1 X Yes 2 No Maryland Prince George's Capital Heights Ö 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 413 Clovis Avenue 20743 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: African 3 X Widowed 4 Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th The White House Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file in and Mental File is marked of မ Matthew Augustus Keel Sr. Nancy Keel Jones other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 413 Clovis Avenue Capital Heights, Maryland Tarsha Keel - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 10. cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Brentwood, Maryland Fort Lincoln Cemetery Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John To-Stewar M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Fatal Cardiac Arrhythmia Medical resulting in death) **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of The law requires that the death certificate be executed and -trar Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 No the 9 Unknown 9 Unknown Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Asthma 1 Yes 2 X No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending ours after death. eral Director: Aft filled in by the fu 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an d title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 06-2011

IJ

Annapolis Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2200

32. Reg

<u>Vanessa Allen</u>

D44864

Glenn Dale, Maryland

May 3, 2012

20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April Physician/ Day Buford Peery Lowe 2012 25 1:15 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkton Care & Rehabilitation Center E1kton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours July 4, 1932 229-92-3530 79 Virginia Director Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil E1kton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country's Funeral 1800 Singerly Road 21921 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 XNever Married 2 Married 2 X No 2 should be filed within 72 hours after thand Mental Hygiene.
27 is marked other than "natural", or traumatic event, the Medical Examir 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unknown unknown unknown unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h 2 Mose Lowe Vicie Lowe . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Rhoda Bosley 226 Mount Street, Rising Sun, Maryland 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Durial 2 Cremation 3 Removal from State West Chester, R.A.Ferris & Co., Inc. 04/27/12 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perrvville. Maryland 21903-0766 21. Sign ture of Funeral Service Ligenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death RENAL Physician/ disease or condition resulting in death) FAILURE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of): and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 N death? this certificate 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After that in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death Accident Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 3 🗌

Br. Mande W

29b. Signature and title of certifier

NARAYANA

31. Date filed (Month, Day, Year)

To the !

126

MD

V-PULA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DOO 65733

11791+

STreet

29d. Date signed (Month, Day, Year)

4/25/2012

12LKTON, MD 21921

Examiner Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Months Days Hours 1 X M 2 □ F 47 Director 220-90-7806 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examining in ust be notified at Anne Arundel Arnold MD Director 10e. Street and Number 10f. Zip Code ö 229 Waycross Way 21012 permit Pages 1 and 2 should be filed within 72 hours after death v Depar ment of Health and Mental Hygiene. Imporant: If item 27 is marked other than "natural", or items 23s any inury or other traumatic event, the Wedical Evantine is ust any inury or other traumatic event, the Wedical Evantine is ust Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled unk 17. Father's Name (First, Middle, Last) Be Donald Jennings Link Alice Coelius 19a. Informant's Name/Relationship (Type. Print) Alice Coelius Osborne 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 03, ___2012 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) metro Crematory, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 495 Ritchie Hwy, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number D0073574 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) milhersville hed 8601 Dr. Karimova Veterens 31. Date filed (Month, Day, Year) State

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Andrew Scott Link 2012 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Birthplace (State or Foreign Country) Aug. 31,1964 Maryland 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc White Specify: 16b. Kind of Business/Industry Disabled 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 Waycross Way Arnold, MD 21012 20c. Location - City or Town, State Baltimore, MD Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the iseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the inference List only one cause on each line. 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ UKATH LONG Nonth / A M 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chapel Hill Nursing Home Baltimore Randallstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Director 217-16-2159 1 🗆 M 2 🔀 F 89 10/10/1922 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 🔀 No MD Baltimore Upperco 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? must be 23a Funeral 5412 Arcadia Avenue 21155 USA tems permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 'natural", or 1 Never Married 2 Married 🗌 Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. white Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene Rosewood St. Hospital dietician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ever once. ည Carroll Edward Long Julia Carlisle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Long, brother 5412 Arcadia Ave., Upperco, MD 21155 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 🔀 Cremation 3 D Removal from State Carroll Crematory 4/25/2012 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 21. Signatur 22. Name and Address of Facility 🗢 моо741 Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final MYOCALSIA Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death for in the past 12 months? Month Day Year Pregnant at time of death detached ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 710 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No the f Accident Suicide Investigation 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 7 29c. License number

Registrar

DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHUSSN C. SIAUONS 2835

APR 2 3 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 8:00AM RITA LEGGET Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Health & Rehab PIG COUNT Wash Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🔽 Hours Min (Month, Day, Year) Director Virginia May 4, 1932 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be not the once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2XXNo Prince George's Camp Springs Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 7100 Eisenhower Court 20748 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò ☐ Yes 2XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XX Specify: Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government D.O.T 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John E. Haskins Rita Mary Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7100 Eisenhower Court, Camp Springs, MD 20748 Kenneth J. Leggett (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5/15/2012 Cheltenham, MD Maryland Veterans Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MD 20735 Ferry Road Clinton Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Coma 0/00 disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 2 1 🗌 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific ame un D35206 ess of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Road Fort WARNington mary/and

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

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gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month_ Physician/ 2012 Robert Harold LeMay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14006 Sea Captain Rd. Ocean City Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Min (Month, Day, Year) 74 Director 478-40-6569 1 DM 2 DF Yrs 5/9/1937 TA 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 ☐ No MD Worcester Ocean City 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21842 14006 Sea Captain Rd. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 Married timore, Maryland 212/15-0036 1 ☐ Yes 2 ☐ No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) the Journalist Associated Press Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Helen Katharine Sauter Leo C. LeMay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is n any injury or other *** Mary Ann LeMay / wife 14006 Sea Captain Rd., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Daurial 2 Cremation 3 Removal from State First State Crem. 5/10/12 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service L 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PANCREATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autonsy death? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 TNO မ 1 Tyes ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No Natural Natural injury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signatur DO05 8410

DHMH 17 Rev 06-2011

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Date filed (Month, Day, Year)

MAY 09

12-03681

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

thel Susan Lars	1	State of Maryland / Department of Certificate of		iene Reg.	No. 2012	1639				
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) Ethel Susan Jean Larson		Date of Death	Day Year	Time of Death 0100 hrs				
- }			c. City, Town, or Location of Death	nay 14, 201	4c. County of Death					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 180-32-1839 1 M 2 X F 71 Yrs.		Date of Birth ((MM/DD/YYYY) 9. Birthol Foreign Counti	ace (State or ennsylvania y)				
any	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Locatio	<u> </u>	01/23/		d. Inside City Limits				
.	tor	Maryland Cecil Elkton	10f. Zip Code	100	. Citizen of What Country	Yes 2 X No				
ith the Maryland 23a or 28a-f sho notified at ooce	D E	10e. Street and Number 558 E1k Mi11s Road	21921		United Sta	tes				
hours after death with the Maryland hatural", or items 23a or 28a-f she Examiner must be notified at ooce	by Funeral	1 Never Married 2 X Married Armed Forces? If Yes 1 Yes 2 X No	Decedent of Hispanic Origin? (Specifs, specify Cuban, Mexican, Puerto Rica ees 2 🔏 No specify:		14. Race - Americar White, etc. Specify: Whit					
24	Completed b	Elementary/Secondary (0-12) College (1-4 or 5+)	s Usual Occupation (Give kind of work st of working life. DO NOT use retired) maker	king life. DO NOT use retired)						
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MD 2121 2 should be f h and Mental 27 is marked matic event,			Address (Street and Number or Rural Office Box 8, Elk			p Code)				
Fe, s 1 and f Heal If item		1 X Burial 2 Cremation 3 Removal from State December of Country of	Cemetery 2012	22,	Bear, DE					
Baltimo permit. Page Department of Important:	Ī	21. Signature of Funeral Service Licensee 22. Na	me and Address of Facility Hick .03 W. Stockton St			ls, P.A. 21921				
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardi				Approximate Interval Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,								
	E	if any, leading to immediate Due to (or as a consequence of): causa. Enter Underlying Causa (Disease or injury that initiated								
be executed ician and urial - transit	dical Ex	events resulting in death) Last d. AMENDED 23a,27,per me,g	928 6-21-12 sm							
6876C certificate nding phys	šľ									
P.O. B es that the d igned by the be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	_	acco use contribute to the					
Division of Vital Records, P.O. Box the Hospital or Atteoding Physician: The law requires that the death hin 24 hours after death. the Fuoeral Director: After this certificate has been signed by the arte optical in by the funeral director, page 2 should be detached for the control of the c	Completed			24a. Was an autopsy performe 1 Yes 2	prior to com ed? death?	sy findings available pletion of cause of				
Vital Rec sysician: The this certificate director, page	To Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check only 3 DOA Other Mursing Ho		esidence 6 🗸 Other: So	cene				
Division of Vital Rec pital or Atteoding Physician: The ours after death. eral Director: After this certificate filled in by the funeral director, page		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	ury 28c. Injury at Work? 28c	d, Describe hov	w injury occurred					
Divis Hospital or At 24 hours after de Fuocral Directely filled in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined (Specify)		or Town, Stat		Route Number, City				
To the Hos within 24 ho To the Fuo completely	edica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occurred at the	e time, date an	d place, and due to the c					
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed <i>(Month,</i> May 14, 2012	Day, Year)				
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltin	nore Street, Baltimore, MD 2	1223						
St		te 31. Date filed (Month, Day, Year) 32. Registrar's Signature								

12-03653 Cletes Eugene Lipp	Please Type or by, Jr. State o 1- For State Registrar	f Maryland / Departme	ole Ink. Ensure All Copic ent of Health and Mental H te of Death	es Are Legible. ygiene Reg. No.	2012 1639
Physician/ Medical Examine	Decedent's Name (First, Middle, Last) Cletus Eugene Lip 4a. Facility Name (if not institution, give s	treet and number)	4b. City, Town, or Location of Death	2. Date of Death Month Day May 12, 2012	Year 3. Time of Death 1845 hrs
Funeral Director		7. Age (In yrs, last birth	Honths Days Hours Min	8. Date of Birth(MM/DD	OPPORT OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "autural", or items 23s or 23s-f show any injury or other traumatic event, the Medical haminer must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Carroll 10e. Street and Number 11916 Good Intent 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If 15. Decedent's Education (Specify only Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Cletus E. Lippy, Some County (10 - 12) 19a. Informant's Name/Relationship (Type Cletus E. Lippy, Some County (10 - 12) 20a. Method of Disposition 1 Name (10 - 12) 20a. Method of Disposition	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Yes, Give Year (Dates: highest grade completed) Colleg-1 (1-4 or 5+) 1ar Co. 8, Print) 19b. 17 19b. 17 19b. 17 19b. 18 19b. 10f. Zip Code 21757 13. Was Decedent of Hispanic Origin? (Signer)	vork done red) Vir (First, Middle, Maiden Sur Stephan tural Route Number, City of Ad, Keymar, Maiden 20c. Loc	Race - American Indian, Black, White, etc. Polify: White Of Business/Industry Peyard Peyard Periown, State, Zip Code) AD 21757 Pation - City or Town, State	
Particular Permit Permi	23a. Part I. Enter the disease, or complice failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated cause.	itions that caused the death. Do not line. Coronary Arter morrhage/Thrombo a to (or as a consequence of):	22. Name and Address of Easilit Fune 412 Washington Roa enter the mode of dying, such as cardiac o y Atherosclerosis w	eral Home and ad, Westminst respiratory arrest, shock, rith Plaque	Chapel
O. Box 68760, at the death certificate be executed by the attending physician and tached for use as the burial - transit Physician/Medical Ex	d. X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	MENDED 23a-b, per me 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 5 9 Unknown ntributing to death but not resulting in	, g927 5-29-12 sm Fetal death 3 Ectopic pregna Other (Specify)	ncy Mo	ate of delivery nth Day Year contrioute to the cause of death?
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transi al Certification: To Be Completed by Fhysician/Medical E)	25 Was case referred to medical	oital: 1	26.Place of Death (Check of Death 3 DOA Other Nursing ne of Injury 28c. Injury at Work?	1 Yes 2 No 24a Was an autopsy performed? 1 Yes 2 No only one) g Home 5 Residence 28d. Describe how injury of	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other:
Divisior he Hospital or Attend in 24 hours after death he Funeral Director: pletely filled in by the ical Certificatic	4 Homicide determined 29a, Certifier 1 CertifyIng Physician:		occurred at the time, date and place, and	or Town, State) due to the cause(s) and ma	anner as stated

Registrar
DHMH 17 Rev 1/2001

29b. Signature and title of certifier

State 31. Date filed (Month, Day, Year)

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day Year)

May 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25. PER MD G928/6/27/12 TRT
State of Maryland / Department of Health and Mental Hygiene

			For State Of Mary 1 - State Registrar		ertificate of D			leg. No. 20	2 16203				
	Physicia	n/	Decedent's Name (First, Middle, Last)	M - M - 1	1		2. Date of Deat	th 201	3. Time of Death				
	Medic Examin	al	Irma Cora Santmye 4a. Facjlity Name (if not institution, give street and number)	r McMul	4b. City, Town, or L	ocation of Death	APRIL	Day Year 7 7013					
	Examin	er	Citizens Nursing Hor	me	Haurel	De6ra	Le	Hars	ord				
T	Funeral			yrs. last birthday Yrs.	y) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth Sept. 2	9. Bir	rthplace (State or Foreign ountry) aryland				
e .	Director		Usual Residence of Decedent	110.			Sept. 2	3,1913 M	aryland				
	yland -f sho	ctor		c. City, Town or					10d. Inside City Limits				
	ne Mar or 28a notifi	Director	Maryland Cecil		10f. Zip Code	yville	1	10g. Citizen of What Co	1 \(\text{Yes 2 \(\overline{\lambda} \) No				
	with ti	Funeral	1455 Principio Furnace Road	i		21903		U.S.A					
	death ritems nerm		11. Marital Status 12. Was Decedent Ever i Armed Forces?	in U.S. 13	3. Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit					
036	s after ral", or Exami	d by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		1 Yes 2 X No	Specify:			White				
5-0	2 hour "natural	Completed	15. Decedent's Education (Specify only highest grade completed)		cedent's Usual Occupat ve kind of work done du		ing	16b. Kind of Business					
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2 ام	filed wall Hygi	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N		· · · · · · · · · · · · · · · · · · ·				
ylar	Menta Menta narkec	입	Clifford Santmye	r			Mollie W	la1ker					
Maryland	2 shouth and the and the strain traum	-	19a. Informant's Name/Relationship (Type, Print) Robert H. McMullen, Jr.	1	ailing Address (Street an 55 Principi			•					
	1 and of Heal item		20a. Method of Disposition	0b. Place of Dis	sposition (Name of	1		20c. Location - City or	-				
<u>im</u>	Page ment c ant: If ury or		1 Burial 2 □ Cremation 3 □ Removal from State Graph of the Control of the Con		rematory or other place, pio Cemeter		05/12 I	Perryville,	, Maryland				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	50	22. Name and Address Lee A. Pat Perryville	terson &	Son Fur	neral Home, 8-0766	, P.A.				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne.											
	Ph_sici_n/) Medical	8 9	Immediate Cause (Final disease or condition resulting in death)	nma					Onset and Death				
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lon	tendir death. tor: Af the fu	Certificate:	2 Accident Investigation		M 1 □ Y	′es 2□No							
Division of Vital Records,	al or At s after o l Direc d in by		4 Homicide determined 28e. Place of Injury - 4 building, etc. (Sp		street, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,				
_	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death, within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier (Check (nation and/or inv	estigation, in my opinion	, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.				
	To the within To the Compl	Σ	29b. Signature and title of certifier	CHAIN R. LONGSON.	29c. License r			9d. Date signed (Mont					
			> Hisupson Min		1146	b4) L		5/3/12					
	_5		30. Name and address of person who completed cause of death	(Item 23a) (Type	1/10/	My	20	181					
	Stat Registra		31. Dat filed (Nonth, Day, Year) 32. Registrar's S	ignature	back								

McMullen, Irma C# 25 cc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 28, 2012 Physician/ Evelyn Marden 06:56 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Oct. 27, 1947 Elkton. MD Director 216-52-1073 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Marvland Ceci1 E1kton 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21921 7 Fawn Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 💆 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ William Payne Cora Dyson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Craft 25 King Charles Circle Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2, 2012 North East Methodist 1 X Burial 2 Cremation 3 Removal from State North East, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signatura Se Se un nsee 22. Name and Address of Facility Crouch Funeral Home, 127 S. Main St. North East, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 15100 After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ျ 1 Tes 1 ☐ Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: of the foundation of the completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29c. License number ompleted cause of death (Item 23a) (Type, Print)

Registrar

State

Registrar's Signature

pinst. 8166011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Apri 30 P.M. ware 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center entre ville Rueen Nursing Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1 Year 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Min (Month, Day, 651 -36-Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Caroline Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21636 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown rving 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beckman Goldsberg, MD 21636 mberli ane 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cambridge 4 Donation 5 Other (Specify) Signature of Funeral Service License Home, PA. Funeral 22. Name and Address of Facility Henry 3 amon dae 510 Washington MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cor 0~a disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ as been signed by the atter in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital Other ည 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending after death. 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one 29b. Signature and title of 12036 Sun 30. Name and address completed cause of death (Item 23a) (Type, Print) مطير n N. Dash OP 764 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month-001ZM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) March 4 . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1925 217-38-6713 Maryland Director 1 □ M 2**X** F 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Mary1and Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r ö with 1 Funeral 21401 USA 502 Royal St. items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status er than "natural", or iter the Medical Examiner Armed Force Black, White, etc. þ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Menta (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Department of Aging 6th Foster Grandparent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Hamilton Rebecca Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21401 Susan Offer(Daughter) 502 Royal St. 20b. Plane of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State Memorial Park 5-7-12 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Winname a Receise of Scilit Sons Mortuary, 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sememally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28h. Time of I Director: After the din by the funeral Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cortific

State Registrar

DHMH 17 Rev 06-2011

me and address of person who

1 cm

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2012 3 10:45A M May Samuel Mackell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blue Point Nursing & Rehab Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 29 1941 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□F Maryland 70 217-38-2009 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14 B Bens Dr. 21401 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th College (1-4or 5+) Ò City of Annapolis Laborer 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Samuel Mackell Martha Hopkins 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Mackell(Daughter) 709 E Newtown Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chews UM Church 5-9-12 West River, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wan Name Redese of &acil Sons Mortuary, Larry & Hees 1922 Forest Dr. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOURSCULAR XISEASS Immediate Cause (Final HYPERTENSIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Maton 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2/200 Other: 4 Hursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Atter 1 Natural
2 Accident Attending Injury Division 5 | Pending 1 Yes 2 No investigation after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year)

BUENUE

cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

(Check only

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Linda Marie Meekins Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 M 2 X F Months Days Country) 59 **Director** 235-84-5673 2/02/1952 Virginia Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked outher than "natural", or items 23a or 28a-f shound or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Prince Georges Forestville Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5710 Burgess Road 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of College (1-4 or 5+) Elementary/Seconday (0-12) Labor Clerk of the Board Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward R. Jones Josephine Berry 19a. Informant's Name/Relationship (Type, Print) Ronald K. Meekins/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5710 Burgess Rd. Forestville, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 5/4/2012 Olivet Cem. Washington, Signature of Funeral Service Licensee 22. Name and Address of Facility M01388 5635 Eads St. Dunn&Sons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i i n Acute Respiratory Failure Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hear sinned by the attacking a minimizer and Pneumonia the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Tyes 1 Alnpatient 2 ER/Outpatient 3 DOA Certificate: To within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) arah Abdulsalam May 8, 2012 D70395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 Forest Glen Rd. Silver Spring, <u>Abdulsalam-</u> 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

12-03499 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Katherine Sarah Morris State of Maryland / Department of Health and Mental Hygiene 2012 16398 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 6, 2012 0536 hrs **Medical Examiner** Katherine Sarah Morris 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 7009 Arundel Mills Circle Hanover Anne Arundel 5. Social Security Number 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Months Days Hours Director 220 27 3284 22 03/11/1990 Country) MD 1 M 2 X F Yrs Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 Yes 2 No MD St. Mary's California Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mentai Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23252 Chestnut Oak Court#1017 20619 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes 3 Widowed Yes, Give Year 1 Yes 2 No specify: Specify: Black 4 Divorced If 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student School 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Willie Morris Marquerite Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 6 1 9 19a. Informant's Name/Relationship (Type, Print) rtment of Health and Mortant: If item 27 is may or other traumatic e Marguerite Morris/ Mother 23252 Chestnut Oak Ct.#1017California,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Cem. Lexington Park,MD 5/12/2012 First Miss.Bapt. 4 Donation 5 Other Specify 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses mbelly 38576 Brett Way Mechanicsville, MD 20659 23d Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and ./Medical Death a. Carbon Monoxide Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Directors. hysician/Medical tending physician : use as the burial -UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify) ned by the atte 1 Yes 2 No 9 ✔ Unknown 9 Unknown ᇤ Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed' death? page ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) å examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred e Bospuss.

n 24 hours after death.

the Funeral Director: A'

""-" in by the ft Subject exposed self to charcoal grill fumes Certification 1 Natural FOUND: Pending 1 Yes 2 ✔ No May 6, 2012 0530 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 7009 Arundel Mills Circle, Hanover, MD determined (Specify) Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number May 6, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registra Patricia Aronica-Pollak MD.

OCME

900 W. Baltimore Street, Baltimore, MD 21223

ORIGINAL

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 3, Physician/ 2012 Joseph Dominic 0634 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre De Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year Days 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 X M 2 - F Hours Min. Director 217 44 3809 1945 Washington DC Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛄 No Maryland 1 4 1 Perry Point 10f. Zip Code 10g. Citizen of What Country? Funeral Circle Drive United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed XX Divorced Year or Dates. Vietnam White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Contractor injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gabriel 4 1 Melice Gloria Virginia Salatte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Burkhouse (Sister) 2636 Mirkwood Court, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 5/10/2012 Suitland, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of E m61140 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Onset and Death Physician Medical resulting in death) Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on CVA Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 4 ☐ Pregnant a 9 ☐ Unknown 2 No 1 ☐ Yes ∠ ∟ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Elevation 2 No 3 Probably 4 Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse(Praditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MXXX 2239 200 03 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) runion are Haure De Grale MD 21078 State MAY 0 9 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9, 2012 5:53 Donald Eugene Metz a M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown 19503 Spring Valley Drive If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) **Director** 1**X** M 2 □ F 295**-**18-8623 01/30/1927 Ohio 85 Usual Residence of Dece than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Maryland | Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 19503 Spring Valley Dr. 21742 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) +4 Personnel Director Automobile Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Louise Benchoff Wiliam Roy Metz permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19503 Spring Valley Drive Hagerstown MD 21742 Metz / Wife Faye altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5/13/2012 Smithsburg, Maryland 21. Signature of Jur eral Service 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Physician/ cardious disease or condition Medical resulting in death) Examiner quentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician. The law requires that the death certificate be a
 24 hours after death.

 Funeral Director: After this certificate has been signed by the attending abovers. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death signed by the at Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Mellitus 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an , page 2 autopsy performed? Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Aspesidence 6 Other (Specify) Hospital 2 NO 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the I

State Registrar 2 □

Mach

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Mone

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

only one)

Willst. Hagerstown, MD 21740. 35 egistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

023815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Medical 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 218-24-8834 Director 78 April 4,1934 Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Williamsport 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 8531 Neck Rd. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black White etc 1 Never Married 2 Married þ 1 X Yes 1955 If Yes, Give 1955 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed 1957 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lineworker Automobile Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cornelius McKinsev Helen Ninamay Boyer .. Page 1 and 2 should by tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Kensington Place Herndon, VA 20170 Tonya M. Embly-daughter 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State GreenLawn Mem. Park 5-12-2012 Williamsport, MD ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licens Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ tarction disease or condition resulting in death) immediate Medical **Examiner** -2012 Sequentially list conditions ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury 1997-2012 the attending physician and ched for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year P.O. á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has perform death? this certificate Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral 5 Pending 2.00 PM 18/2012 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. My dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Examiner: Number Testitioner: Testing in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place as 2 due to the cause(s) and manner stated. (Check RIDD 668

JN-9+1

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ McClure Brooks Manth 2,2012 4:30a м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Hours 3/08/1919 130-12-9481 93 Director 1 XM 2 □ F N.Y., N.Y. Usual Residence of Decedent 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 X Yes 2 □ No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8100 Connecticut Avenue 20815 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Medical Examiner Armed Forces' 9 Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 No filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White "natural", Year or Dates. WWII 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Journalist Newspaper event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McClure Angelica Walter Harsha Mendoza ge 1 and 2 should it of Health and IV If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)20852Thomas Donohue/Attorney 11140 Rockville Pike Suite 580 Rockville,MD Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ō 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or Chesapeake Crem. 5/5/2012 Beltsville, Md 4 Donation 5 Other (Spec 21. Signatury f Funeral Service PHILIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Medical attending properties for use as as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year g | Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed cardiomyopathy, renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 🗌 Yes 2 🗀 No 2 **X** No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Hospital: 1 Yes ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending iniury Division ☐ Accident ☐ Suicide Investigation within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 06-2011

(Check

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandra Delisthathis MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D59980

8700 Old Georgetown Rd Bethesda, Md.

29d. Date signed (Month, Day, Year)

May 3,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Anne Arundel Linthicum If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 578-38-6465 1 🕅 M 2 🗆 F Yrs. Washington DC 04/14/1929 83 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21037 USA 1201 Locust Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes 2 No Specify: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 3 Divorced 4 Divorced Completed White Year or Dates. 1948 - 5115. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Company 12 Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dolores Bradley John Maher permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Locust Lane, Edgewater, MD 21037 Carolyn Maher / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/7/2012 Kalas Crematory Edgewater, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Teath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and al-transit The law requires that the death certificate be executed that initiated events physician ar is the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnate 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown the 9 Unknown P.O. I signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 performed 2 No 1 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spec To the Hospital or American within 24 hours after death.

To the Funeral Director: After this manufactor, filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pendina 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Example: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of 5×1 ne and address of person who completed cause of death (Item 23a) (Type, Print) State MAY 08 2012 Registrar

DHMH 17 Rev 06-2011

Amend	item	# #1	5-Cecil 8	CO Head	e Type	8PÞrixA	in Blaci	k Indeli	ble Ink	k. Enst	ure All	Copie	s Ar	e Legibl	e.		
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	= e o	199	23a. Part 1. Enter shock, or he	the disease,	omplications the	hat caused the c	death. Do no	635 (enter the mo	hurri ode of dying	g, such as c	s Roa ardiac or r	espiratory a	rrest,	K.DE 19		Approximate	
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P.O. Be	by the attached	Physi	9 Unknow	n	9 □ (Jnknown									_		
S, P.	been signed by the should be detached		Part II. Other sign	ificant conditions	contributing	to death but not	t resulting in	tne underlying	g cause giv	en in Part I.						cause of death? bly 4 T Unkn	-
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on o	eath. or: After	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investiga	tion (A	Month, Day, Year	r) inju		work?	Yes 2 1		d. Describe I	now inju	iry occurred			
)ivisi	s after death. Director: A in by the fu		4 Homicide	6 Could no determine	28e. P	lace of Injury - A uilding, etc. (Spe	At home, farm ec <i>ify)</i>	, street, facto	ory, office		28	f. Location (City or Tov		nd Number or e)	Rural R	oute Number,	
Division of Vital Records, P.O. Box 68760	within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check	2 📖 Medical Exa	ıminer: On the	he best of my kr basis of examin	ation and/or i	nvestigation, i	n my opinio	n, death occ	curred at th	e time, date a	and plac	e, and due to the	ne caus	e(s) and manner s	stated.
of the	within To the comple	Σ	29b. Signature an				of my knowled		9c. License	number		and due to tr		ate signed (Mo	n <i>th, D</i> a	y, Year)	
			30. Name and add	ress of person wh		cause of death (Item 23a) (Tv	pe, Print)	500	2332	-			5.4.		12.	
D			S.S &	A41DE	VM.	D 12	64	5 this	40	E	LKI	TON	MI	249:	21.		_
	Stat Registra		S., Date filed (IMOI)	, ouy, 10a1)	3.	2. Registrar's Si	AY 7	2012	Denne	m /	A. A	barke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 7:26 AMMorehead Nathaniel Walter pril Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Bowie 3923 Elan Court 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral** 1 X M 2 - F Days Hours Min (Month, Day, Ye North Carolina Director 242-60-4004 70 1941 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location aţ permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Medical Examiner must be notified Bowie 1X Yes 2 ☐ No Prince George's Md 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 20716 USA 3923 Elan Court items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than ' College (1-4 or 5+) 5+ Elementary/Seconday (0-12) the Lawyer and Educator Prince George's County ath and Mental Hygie
27 is marked other
r traumatic event, tt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mattie Brooks Nathaneal Sylvester Morehead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Fort Washington, Md 12805 Clarion Rd. Natalie Brown / Daughter altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 05/14/2012 Brentwood, Md 21. Signature of Funeral Service 22. Name and Address of Facility Fort Lincoln Funeral Home retar raices 20722 Brentwood, Md 3401 Bladensburg Rd 23a Part 1. Enter the cleekse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ENO. scientre Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): resulting in death) Last signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Unknown 1 Yes 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 4 Nursing Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Seath 28b. Time of 28c. Injury at work? 1 \(\text{Yes} \quad 2 \text{ \subset}\) No 28d. Describe how injury occurred : After t injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29d. Date signed (Month, Day, Year) 10 and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Hone MAY 2012 6:55P Medical 4a. Facility Name (if not institution, give street and Amber) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CO. NURSING & REHAB. CNTR LA PLATA CHARLES 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) Country) **Director** 1 M 2X XF 216-88-3474 49 09-13-1962 COLORADO Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1

Yes 2 □ No CHARLES LA PLATA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be Funeral 23a U.S.A. 10200 LA PLATA ROAD 20646 items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ō þ Never Married 2 Married Yes Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2x No Specify: "natural", WHITE Completed 3 ₩idowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) DISABLED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM S. MAGGI ANN J. MORIARTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 17323 BAKERSVILLE RD., SHARPSBURG, MD 21782 GAIL PANNILL / SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date MAY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) VETS.CEMETERY 14,2012 CHELTENHAM, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility RAYMOND FUNL. SERVICE.P.A. any on 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): nding physician Physician/Medical death certificate be Box 68760 the as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Year 5 Other (specify) Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a. Was an page 5 autopsy performed? 1 Yes 2 N Degia Hospital or Attending Physician: Division of Vital 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: 1 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending X Natural work? 2 🗆 No 24 hours after death Funeral Director: A Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar h, Day, Year) Y 2 2 2012

Registrar's Signature

Name and address of person who completed cause of death (Item 23a) Type, Printibion BIVD, Ste B, Gren BW716, MD, 21061

05/09/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Amend Item 25	State of Marylan per me, g927,	85/AP/	2012ahB	lealth an	nd Mental Hy	giene		
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	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	r Location of D		4c, Count	y of Death	
- No.	پا ن		ST. THOMAS MORE 5. Social Security Number 6. Se	E NURSING HO		HYA If Under 1 Year	TTSVI		PRIN		GEORGE 'S place (State or Foreign
	Funeral Director			П•М 2□ Е	Yrs.	Months Days		Min. (Month, Da	ay, Year)	Coun	ntry)
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the AA	or 28 e noti	Dir	Md. Prince	deorges		10f. Zip Code			10g. Citizen of	What Cour	ntry?
with	is 23a nust b	Funeral	6154 Springh:				2077			ced S	States
13-0036	fall Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ★Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🂢 No		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin' an, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)		ice - Americ ack, White,	
3-0036	ral", c	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 ☐XNo	Specify:		Specif	y: B1	lack
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yland Id be filed	d Mental Hygie marked other matic event, th	2	Moses McIver	, Sr.	ura E. M	McCoy					
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a	f Health and Men item 27 is marke other traumatic		Jimmie McIver/ 20a. Method of Disposition	20b. F	Place of Dispo	Jasper osition (Name of	1	SE #4	Vash., 20c. Location		20020 own, State
OW.	2 = 5		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donaţion 5 ☐ Other (Specif	nemoval nom state		natory or other place ake Cren		-]	Belts	sville, M
Baltimo	Departmen Important: any injury once.		21. Signature Funeral Service Licens					Capitol			
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ou ate be executed	physician and s the burial-transit	edical		d			-181	CATION APPROVED BY		\rightarrow	
	ding pl	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy		CERTIF	(0)			
Geath ce	attend I for us	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of o	al death 3	Ctopic pregnand Other (specify)	су			ate of delivi	Day Year
ב Hed	by the tached	hys	9 Unknown	9 Unknown							
r that	igned be de		Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	underlying cause giv	ven in Part !.				the cause of death?
ecords, e law requires	been s	etec		1	···			24a. Was			posy findings available
	e has age 2	Completed	Sub dural l	remorinage		<u>.</u>		— auto	opsy ormed?	prior to co death? 1 \(\sum \) Yes	ompletion of cause of
VITAI K vsician: Th	rtificat ctor, p	Be C	25. Was case referred to medical			26. PI	lace of Death (1 ∐ Yes 'Check only one)	2 140 NO	T Lies	2 110
r VIT Physic	this ce al dire	၉	1 to Yes 2 LINO	Hospital:			4 L Nursi	ing Home 5 Res			y)
	h. After I funer	cate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	yat ⟨? Yes 2 ☐ No		how injury occur	rred	
DIVISION OF	ector by the	Certificate:	2 Accident Investigatior 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At ho				28f. Location		ber or Rura	il Route Number,
ב <u>ו</u>	urs affe ral Dir lled ir			building, etc. (Specify				City or To			
Hosp	within 24 hours af er death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Exami	sician: To the best of my know iner: On the basis of examinatio se Practitioner: To the best of a	n and/or inves	stigation, in my opinio	on, death occu	rred at the time, date	and place, and d	lue to the ca	ause(s) and manner stated
To the	within To the compl	Σ	only one) 3 LJ Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the best of the	my knowledge	29c. Licens	_	and place, and due to	29d. Date sign		
	-		-	- W		D006	63681		4/3	0/201	12
			30. Name and address of person who o	ompleted cause of death (Item	n 23a) (Type, I	Print)			1	1	
	Sta	e	A j i t Kurup M 31. Date filed (Month, Day, Year)	1835 Uni	ivers	ıty Blvo	1. #20	18 Hyat	tsvill	е, Мо	1. 20783
	Registra		31. Date filed (Month, Day, Year) NAY 1 7 2012	Serger D.	par	Les					

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ TYRONE EARNEST NEWMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Medica Plata CIVISTA harle La . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 1 **X** M 2 □ F Days JULY 20.1946 220-42-1264 65 MARYLAND Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits Director ms 23a or 28a-f s must be notified 1 🙀 Yes 2 🗌 No MARYLAND CHARLES BRYANS ROAD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 208 GENTRY COURT 20616 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. Completed by 1 X Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BIACK 3 Widowed 4 Divorced Year or Dates er than "natura", the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 11TH GRADE (0-12) College (1-4 or 5+) MASONARY CONSTRUCTION is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RAYMOND JAMES KING, JR. ELIZABETH NEWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. STACEY D. STRINGER / DAUGHTER 4087 INDIAN HEAD HWY.#3, INDIAN HEAD, MARYLAND 20640 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) HERITAGE MEMORIAL CEM MAY 12,2012 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ature of Fuperal Service Licensee Johnson Moo583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final moistive Physician/ astructive Duranany disease or condition resulting in death) Medical Due (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): ttending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No for Day Year Pregnant at time of death Unknown g 🗌 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sarcoldosis 1 ☐ Yes 2 ☐ No 3 📈 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) selling 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 530 AM KAREN A. NEAVES 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FRANKLIN SQUAFE HOSPITal Rosedal Battimore If Under Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral Days Hours Min. (Month, Day, Year) 6/15/1943 234-68-7052 1 🗆 M 2 💢 F WV **Director** 68 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits 10a. State Director MD Harford Darlington 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21034 USA 1955 Glen Cove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Machine Operator 11 Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ပ Alice Reilly Charles Blankenship Negue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1955 Glen Cove Road, Darlington, MD 21034 19a. Informant's Name/Relationship (Type, Print) Jerry R. Neaves/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State Evans Eagle Crem. 5/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Leola, PA 21. Signature of Fundal Service Ace De Harkins Funeral Home, Inc., Delta, PA 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Preumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death detached 1 Yes 2 4 9 Unknown the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hospital or Attending Physician; The law requires Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has a director, page 2 s performed? Yes 2 No 1 Yes 2 No after death.

Director: After this certification by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No М 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a
To the Funeral C
completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DR masoud 31. Date filed (Month, Day, Year) MAY 2 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dahanmir

Registrar DHMH 17 Rev 06-2011 29c. License number

9000 FRANKLIN SQUARE DR BOLTO md

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#5perINF, 5/10/12; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year Physician/ KATHLEEN MONICA O'BRIEN MAY 2012 7:50p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY 3594Sec418 Number 57 If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day Month Hours Min **Director** Usual Residence of Deci permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be accepted. Director 10a. State 10c. City, Town or Location 10d. Inside City Limits FAILERA 1 Yes 2 No RING 10e. Street and Number 10g. Citizen of What Country? Funeral DR. 2215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CAtholic 04 AND FIFTHERY rector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KAMPHAUSEN 2 Fletcher BARNICLE MUZIF JUNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAINTED DAISY DR 7842 JoHn Lawrence O'Bried/HuseauD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location -Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12012 FAILS CHUNCH, 4 ☐ Donation 5 ☐ Other (Specify) ATIONAL CREMENTORY Signature of Funeral Service License 22. Name and Address of Facility 5308 Backlick C0517 emaine tome 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani Drain disease or condition daVS Medical resulting in death) Examiner Sequentially list conditions Examine frank, leading to himself cause. Enter Underlying attending physician and for use as the burial-tr To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ ★es 2 ☐ No Pregnant at time of death Month Day Year ed by the a 9 Unknown has been signed by e 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 Yes 25. Was case referred to medica 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? (Month, Day, Year) Natural 5 Pending within 24 hours area ...

To the Funeral Director. After ...

To the funeral Director. 1 ☐ Yes 2 ☐ No ☐ Accide*n*t ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20 D0068466 05/02/2012

State Registrar

32. Registrar's Signature

10 CENTER DRIVE, BETHESDA.

MARYLAND 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHARINE MCNEILL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Maxine Pieper May 2:50 P M 09 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Westminster 4c. County of Death **Examiner** Emeritus of Westminster Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours 481-12-7841 Director 1 □ M 2 🛣 F vov. 01, 91 1920 Íowa Yrs Usual Residence of Deced 28a-f shov 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits Maryland Carroll Westminster XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Rd. 21157 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐No Specify Specify: Completed 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Floyd Brown Jennie Lynn Blanche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin D. Pieper/Son 102 Vegas Dr., Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 05/14/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22Prietts of Penetral Home and Chapel, P.A. N Mr. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for in the past 12 months?

1 Yes 2 No Pregnant
Unknown Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner s after death. Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Cheek Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h. Signature and title of certifier 29d. Date signed (Month, Dat. Year)

Registrar
DHMH 17 Rev 06-2011

State

Vacks

completed cause of death (Item 23a) (Type, Print)

address of person who

4 2012

31. Date filed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 4, 2012 1741 Franklin O'Brien Poole M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 226-64-3040 Director 1 X M 2 □ F 63 June 9, Usual Residence of Decedent Virginia show Department of Health and Mental Hygiene. Income area treatment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Prince George's Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3192 Shadow Park Lane 20603 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 2 XNo If Yes, Give 1 ☐ Yes 2 🛂 No Specify: Specify: African American 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Contract Specialist D C Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ada Henderson Moses Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Omar A. Poole - Son 3192 Shadow Park Lane Waldorf, Maryland 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 2012 Suitland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewar 4001 Benning Road NE M00560 Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death tic Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine HIV the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 2 No 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cytomegalowns 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsv 2 ANO 2 No Yes 1 Yes Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to edical examiner? 26. Place of Death (Check only one) Be Hospital 2 No 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a

Registrar

DHMH 17 Rev 06-2011

State

4701 Randolph Pd + ZIG, ROCKVILLE MB 2085Z

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1840 RN 2012 0.5 Medical County of Death 4a. Facility Name (if not institution, give street and numb Town, or Location of Death **Examiner** If Under 24 Hrs. Birthplace (State Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min **Director** 1 M 2 □ F death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 □ No Zip Code 10e. Street and Numbe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced ac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb 20a. Method of Disposition 20b. Place of Disposition (Name of City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of acility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIAC Physician/ FATAL THMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HEPATO Sequentially list conditions, Physician/Medical Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred work? 1 📈 Natural 5 Pending 2 No filled in by the Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the dead of the dead of the cause of the cause(s) and manner stated of the cause(s) and manner stated of the cause(s) and manner stated of the cause(s) and manner stated of the cause(s) and manner stated of the cause(s) and manner stated of the cause(s) and manner stated of the cause o Tpletely (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Ho

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 20/2 Rosemary Payne 744 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO REGIONAL MEDICAL SALISON 14 Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Maryland Months Hours 218-48-7208 Director 1 □ M 2 F 64 2/18/1948 show at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Pocomoke City 1 Yes 2 No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ms 23a or must be r Funeral USA 21851 2437 Stockton Road er than "natural", or items the Medical Examiner mu and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 → No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk ed other 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ano. of Health an. tetem 27 is man. retraumatice မ Alice Mae Adkins Francis Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2437 Stockton Road, Pocomoke City, MD 21851 Ronald Payne/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō <u>=</u> 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9 Department Important: If any injury or 5/6/2012 Pocomoke City, MD First Baptist Cem. Donation 5 Other (Specify) 21. Signature of Funeral vice 22. Name and Address of Facility 22. Name and Address of Facility
Holloway Funeral Home, P.A. Poomoke City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final TUMOR Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Exami the burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown this certificate has been signal director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 19 a) \$500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL ST, SALISBURY, MD BA 6

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16415 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25^{ay} 2012 Year April Waymon Felix Putnam 6:15 p м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall St. Marys Charlotte Hall Veterans Hospital 8. Date of Birth (Month, Day, Year) April 24,1928 North Carolina Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Min. 1 XM 2 □ F Hours 413-36-7999 84 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Colora 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21917 U.S.A. 2239 Colora Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 XYes 2 Black, White, etc. or 2 should be filed within 72 hours after thand Mental Hygiene. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Gambill Concrete Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver White Marsh, Maryland Ten Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mallie Putnam Euna J. Aldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Sally Haywood (sister) 2239 Colora Road, Colora, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place) HOTIV HITI Memorial Gardens 1 A Burial 2 Cremation 3 Removal from State 04/28/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. BCORTICA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year ed by the a g Unknown P.O. cate has been signed by page 2 should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 X N 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) PRIL HO037228MD 26,2012

State Registrar 31. Date filed (Month, Day, Year)

2+149

DHMH 17 Rev 7/2009

Stephen Cafferty, M.D., 100 Hospital Road, Prince Frederick, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Miguel Alejandro 2<u>012</u> Physician/ Parra Month <u>12:</u>25 ам May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14409 Gunstock Court Silver Spring Montgomery 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours **Director** 1 X M 2 | F 3 2, Dec. 2008 Maryland 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral 14409 Gunstock Court 20906 ral", or items? death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 X Never Married 2 Married 2 X No Maryland 21215-0036 should be filed within 72 hours after 1x Yes 2 □ No Specify:Colombian If Yes, Give "natural", Specify: White Completed 3 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. narked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Angel David Parra Victoria Eugenia Gomez and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Angel David Parra/Father 14409 Gunstock Court, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. Date 8 Mav 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 2012 Glen Burnie, MD 22. Name and Address of Facility Color Funeral Services #100, 4110 Aspen Hill Rd., #100, Rockville, MD 20853 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part 1. Enter the disease, or co Approximate shock, or heart failure. Lis Immediate Cause (Final Onset and Death Physician. Acute Myeloid Leukemia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or Injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as attending plant for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has autopsy performe certificate 1 Yes 2 No Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2XX No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Hospital or Attending injury work? 5 Pending Accident
Suicide death. neral Director, A Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifie 29c. License number D37142 May 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, #100, Rockville, MD 20850 G. Coleman, MD

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day,

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O3 Charlotte A. Pusey 6:50 am May 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 217-46-7728 1 DM 2 X F 11/20/1943 Maruland 68 Page 1 end 2 should be filed within 72 hours efter death with the Maryland ment of Health and Mentel Hygiene. Issut: If Item 27 is merked other then "natural", or Items 23a or 28a-f show ury or other traumetic event, the Medical Examinat must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maruland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 U.S.A. 3517 S. Leisure World Blvd. 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give ģ Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Calvin Wolfe Helen Grey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3517 S. Leisure World Blvd., Silver Spring, MD 20906 Larry Pusey - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 05/07/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MOISIGH Kath 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Abdominal Carcinoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or miju y that initiated events resulting in death) Last Examine Due to (or as a consequence of): within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by this funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending housing and the second of the sec Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 X No Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Small Bowel Obstruction Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Bladder Fistula 24a. Was an autoosy 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🗘 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number R143201 5.3.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP, 6001 Muncaster Mill Road, Rockville, Maryland 20855 Debrah Miller 31. Date filed (Month, Day, Year) MAY 04 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and M	Mental Hygie	ene	0 1611					
		1 - State of Maryland / Department of Health and Mental Hygiene per FH 5/8/12 Certificate of Death 1. Decedent's Name (First, Middle, Last)										
	Physicia Medic		Russell Phillips		2. Date of Death	Day 20 Year	3. Time of Death					
,	Examin		4a. Facility Name (if not institution, give street and number) Prince George's Hospital	4b. City, Town, or Location of Death		4c. County of Death	eous					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs, Months Days Hours Min.	24 Hrs. 8. Date of Birth 9. Birthplace (State							
	show d at	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.		1101123	7,730,						
	arylan ia-f sh ified a	Director	Machine				10d. Inside City Limits 1 ✓ Yes 2 □ No					
	the M or 28 e not	Dir	DC Washing	10f. Zip Code	10	g. Citizen of What Cou	/hat Country?					
	vith s 23a nust b	Funeral	5209 Blaine St., NE	20019		United S	States					
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	þ	Armed Forces? 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 X No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:		14. Race - Amer Black, White Specify:	e, etc.					
2-0	hours hatur dical E	olete	15. Decedent's Education 16a. Dece	edent's Usual Occupation skind of work done during most of work	ina 16	6b. Kind of Business I	ack Industry					
Maryland 21215-0036	ithin 72 ene. • than " the Me	Completed		Nitid of work doring during most of work DO NOT use retired) Auditor	ing	Govern	mont					
<u>م</u>	filed wall Hygi dother	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		iiC11C					
ıylaı	uld be d Menta marked natic e	오	Christopher Phillips	Minni								
	nd 2 sho ealth and m 27 is i her traur		Mark Phillips/brother 426	ing Address (Street and Number or Rura D. East Capitol Dington, DC 20	Stor NE	#3						
Baltimore,	Page 1 all ment of Hamment of Hammer If itel ury or oth		20a. Method of Disposition 1 Burial 2 又 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	osition (Name of Hale Unk	Date 20	Dc. Location - City or $1 - 1 = 1 = 1 = 1$	Town, State Unk OH					
Balti	permit. Page 1 Department of Important: If i any injury or once,			2. Name and Address of Facility Hoo 3910 Silver Hil								
П			23a Yart 1. Enter the disease, or complications that caused the death. Do not entertail the state of the stat	ter the mode of dying, such as cardiac o	or respiratory arrest	,	Approximate					
	Physician/ Medical	8 0	Immediate Cause (Final disease or condition resulting in death) a. Arterios de of the condition of the co	Ic HyperTenen	e Henri	Disem	Opet and Death					
المعددة	Examiner	_	Sequentially list conditions,									
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of):								
	ate be executed bhysician and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):									
760	cate be physic s the bu	edical	d									
Box 68	death certificate be executed ne attending physician and ed for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Y						
	t the de by the tached	Physi	9 Unknown 9 Unknown		<u> </u>							
ds, P.O	requires that the de been signed by the. should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	the cause of death? obably 4 Unknown					
Records,	sician: The law requires that the certificate has been signed by the lirector, page 2 should be detach	Completed			24a. Was an autopsy performe	prior to c death?	copsy findings available completion of cause of					
	ysician: The is certificat director, pa	Be C	25. Was case referred to medical examination	1	No 1 ☐ Yes	2 No						
Ĭ	Physic this ce	၉	Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		ome 5 🗆 Residenc	ce 6 Other (Specif	fy)					
<u> </u>	iding F th. After 1 funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) (Month, Day, Year) 28b. Time of injury	of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred						
Division of Vital	Hospital or Attending Physician: 24 hours after death. Funeral Director. After this certificated filled in by the funeral director,	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check check only one) 29a. Certifying Physician: To the best of my knowledge, death check only one) Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	the time, date and p	place, and due to the ca	ause(s) and manner stated.					
	To the within To the Comple	Σ	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,						
	h		Jalorda // ropor DO	40053727	17	god 24,	20/2					
	Th		30. Name and address of person who completed cause of death (Item 23a) (Type, SAVA SON SON SON SON SON SON SON SON SON SON	Print) spital Drin	e Ch	Everly.	ringlad					
	Stat Registra		31. Date filed (Month, Day, Year) NAY 0 88012 32. Registrar's Signature	l.		0'	v					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Audrey Ann Jenkins Payne April 30, 2012 1700 hrs. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 🗙 F Washington,D.C. 215-24-2161 1925 86 July 1, **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shevent, the Medical Evander rust be notified. 1 XYes 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 United States 26 New York Avenue, N. W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 th No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 **Black** 2 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mayflower Hotel 9th grade Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 36 permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev William Jenkins Roxey (unknown) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerry Maurice Payne(Grandson) 26 New York Avenue, N.W.; Washington, D.C. 20001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Glenwood Cemetery May 8,2012 Washington, D.C. 21. Signature Funeral Ser 22. Name and Address of Facility R.N. Horton Company Morticians, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inc,;600 Kennedy Street, N.W.; Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acote **Physician** MYUCARMAI IN FARETION HOURS /Medical Due to (or as a consequence of): **Examiner** ARTORIOSCIENODO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): Box 68760. physician certificate be Physician/Medical attending for use as yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the Yes 2 No Ö 9 Unknown 9 🗌 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed abetes Mollifier 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy page certificate 25. Was case r ferred to medical examiner? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No of Vital Physician: director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 22 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

03 Queensbury ld ityattsvillell 200781

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D Day Physician/ Month Edna Mae Poole РМ May 2012 3:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airv Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min (Month, Day, Year) 214-34-2228 Director 1 □ M 2 1 F 94 Oct. 27, 191 Maryland Usual Residence of Deced 10a, State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Frederick Monrovia MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21770 4639 Ed McClain Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Cook Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlotte Elizabeth Gore Basil David Cashour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $4705\ ext{Mussetter}\ ext{Rd.,}\ ext{Ijamsville,}\ ext{MD}\ 21754$ Raymond Poole/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 05/17/2012 Mt. Airy, Maryland Prospect Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral Home M01646 Frederick, MD 21701 St.. 106 E. Church 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition) Medical resulting in death) Due to (or as a con uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at tirne of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ pice 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation after death Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) NAY 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 Month May Physician/ 8:10 a. M 11 Judy Lee Riley Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 232-60-8141 Director 1 □ M 2 🗶 F 73 Yrs April 4,1939 Keyser, WV Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Havre de Grace MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20178 USA 328 Lapidum Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) County School System Instructional Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, should be file and Mental H 2 Louise Norwood John Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) arnit. Page 1 and 2 startment of Health a portant: If item 27 is John W. Riley, Jr./Husband 328 Lapidum Road Havre de Grace, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State May 17 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2012 Keyser, WV 22. Name and Address of Facility Smith Funeral Home Der Jung 85 S. Main Street Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ u disease or condition Medical resulting in death) Due to (or as a consequence of): TREINOMA' **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ADYNAMI Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 D No that the death Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 🗌 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury 28b. Time of of 28d, Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending Division 2 🗌 No Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 0 Medical TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Jom

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

Ekunola Alade 500 upper Chesapeak Drive Bel Air mo 31014

31. Date filed (Month, Day, Year)

NAY 2 3 2012

Mil)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Carlos Rhoten, Jr. <u>11:1</u>7p ^M /25/201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Hospice Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 218-40-2421 Director 1 ★ M 2 🗆 F 70 Yrs 11/17/1941 MD Usual Residence of Decede or 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified Carroll Hampstead MD 1 🗆 Yes 2 🛶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 23a (Funeral must 21074 USA 2818 Shiloh Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter Armed Forces Black, White, etc. 1 Never Married 2 Married 0.10 þ 1 Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates than "nature he Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. the B & P Paving truckdriver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William C. Rhoten, Sr. Edna Rosena Close 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other traconce. Frances Rhoten, wife 2818 Shiloh Road, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/29/2012 Carroll Cremation Hampstead, MD 22. Name and Address of Facility 21. Signature of Juneral Service Licensee M00741 Eline Funeral Home St., Hampstead, MD hand S. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENAL Physician disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of) Examiner MELLITUS Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury YPERTENSION The law requires that the death certificate be executed tran and that initiated events Due to (or as a consequence of resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No detached 9 Unknown Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Q 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PULMOUNY Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Cher (Specify) AMEST HSP (CE 1 🗌 Yes မ 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work' 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd title of certifier 29b. Signature D0040012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Scott Poulton, 405 Frederick ROAD, Suite 204, Catonsulle, MO 21328

State Registrar rougron)

APR 3 0 2012

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 30,2012 Physician/ 1:00P M BEATRICE RUNKLES GRACEY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director 214-28-5081 1 M 2 XXF 96 July 21, 1915 Maryland Usual Residence of Decedent show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 East 16th Street 21701 United States be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian. 11 Marital Status Armed Force 1 Never Married 2 Married þ Yes 2**XX** No Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elmer Beachley Gertrude McBride 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Linda Smith / Daughter 401 Glade Blvd., Walkersville, MD 21793 other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State jo Jo Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State May Pleasant View Cemetery Burkittsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Meral Serv Resthaven Funeral Services, Skkot Cody P.A. Catoctin Mountain Hwy. Frederick. 23a. Part 1. Enter the disease shock, or neart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Betweer Immediate Pause (Final disease of condition Onset and Death Proviotan/ Duhduna) Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical l or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy this certificate has been signed by the atter ral director, page 2 should be detached for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical exampler?
1 ☑ Yes 2 ☐ No the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 4/2 g | 12 | 1 Am M 1 28e. lace of Injury - At home, farm, street, factory, office building, etc. (Specify) injury Caboca 1 Aatural 2 Accident 5 Pending Fall 2 No 1 Yes Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Bural Boute City or Town, State) 200 East 16 FYEULEVICK, MD determined North hampton NUrsing hemi Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of and title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year) D5164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 3^{Day} Physician/ 2012 Year 1:30 P George Carlton Rhoderick IV Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mt. Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Davs (Month, Day, Year) 215-26-9131 88 Director **1x**□ M 2 □ F Yrs 11/9/1923 MD Usual Residence of Deced 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director must be notified Frederick MD Middletown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 21769 USA 6 Broad St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status Bace - American Indian. Armed Forces? Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 1946 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) publisher owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olive Bowlus 2 George C. Rhoderick Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 Broad St., Middletown, MD 21769 Adrienne Rhoderick (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cren ition 3 Removal from State 5 Ster (Specify) Lutheran cemetery 5/8/2012 Middletown, MD 22 Name and Address of Facility Donald B. Thompson Funeral Home Sign ce Zicensee 18. Middletown, MD 21769 dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Enter the disease, or or heart failure. List or Immediate Cause (Final Physician/ 9880-1960 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No Division of Vital 26. Place of Death (Check only one) Be 25. Was case referred to medica Hospital Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: the Hospital or Attending thin 24 hours after death. 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

1 Yes 2 No

Year

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0028 Medical 4a. Facility, Name (if not institution, give street and number) **Examiner** 4c. County of Death ltimure Social Security Number 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 16 1332 815 1 🗆 M 2 💢 Director MD 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Carroll Hampstead 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r USA Funeral 3800 Sunnyfield Ct., Apt 1C 21074 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify. white "natural" Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Walmart greeter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Thomas Stanley Hale Hester Eleanor Baublitz traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 Kessinger Dr., Myrtle Beach, SC 29575 Peggy J. Wright, daughter it of Health : altimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If i any injury or conce. 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Mt. Zion UM Cemetery 4/23/2012 Upperco, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M00741 934 S. Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, Exami the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Pregnant at time of death Linknown 9 🗌 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ 1 XInpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 □ Yes 2 □ No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Evelvn Grace Seek May 12:10P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 307 Carriage Run Road Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8 Date of Birth Days Hours Min. (Month, Day, Year) Director 205-16-1954 1 □ M 2 🕅 F 88 July 15,1923 Pennsylvania show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 28a-f Maryland Anne Arundel Annapolis 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 307 Carriage Run Road 21403 USA death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Government Be Department of Health and Mental Hy, Important: If item 27 is marked we any injury or other the poner. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Henry Wilson Albright Mae Belle Stull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Fitzpatrick/Daughter 307 Carriage Run Road, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 5/5/2012 Edgewater, Maryland 21. Signatur f Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Failure To Thrive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Alzheimer's Dementia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ģ 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 24 hours after death.

• Funeral Director: After this certificate has been signed in the funeral director, page 2 should to the funeral director, page 2 should to the funeral director. 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 🗓 No death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XI Residence 6 Other (Specify) မှ 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation

Hospital

within 24 hor To the Fune completely fi

Medical

29a. Certifier

29b. Signature

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31. Date filed (Month, Day, Year) State 2012 MAY 07 Registrar

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determined

Erika M. Benns, M.D. 139 Old Solomons Island Road, Annapolis, MD. 21403 32. Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 5/4/2012

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

🛪 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security Nul 213–24–92	75	Sex 1 M 2 □ F		. last birthday) Yrs.	If Under 1 Months	Year If Und Days Hour	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da 10/31/					
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the at	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										Month Day Year			
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To the Hospital or Attend within 24 hours after death To the Funeral Director; 6 completely filled in by the 1	Medical	(Check 2	Certifying Ph Medical Exa	miner: On the ba	asis of examinat	tion and/or inves	tigation, in my	y opinion, deat	th occurred a	it the time, date a	and place,	and due to the	cause(s) and m	anner stated.	
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JA		30. Name and addres	ss of person who	completed cau	use of death (Ite	em 23a) (Type, I	Print)	1/2	1, A	- 1/A	0	7	1/10	0/7/	
State		ABD U 31. Date filed (Mon	AN Year) a.	(HIZEL)	egistrar's Sign	1 L & 2	-1-0	AKM	11 4	12. M	YER	Slowa	. / ٧٩).	4142	
State Registra			MI T. T.	WILL T	Salar Solgi	M. A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ Esther Lorraine Saunders Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 221 East Ave. Washington County Hagerstown Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year) Days Hours Min Months 220-40-0448 Director 1 🗆 M 2 💢 F 70 Jan. 24,1942 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 □ No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 221 East Ave. 21740 U.S.A. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status ral", or iten Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Board of Education 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ David Elmer Long Edna Mae Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Martin-daughter 122 B Nottingham Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Broadfording Mem. Burial 2 ☐ Cremation 3 ☐ Removal from State 5 5-13-2012 Department or Important: If any injury or Hagerstown, MD ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility louglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) VAS (con 4000 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Year Day Pregnant at time of death 1 ☐ Yes ∠ ⊑ g ☐ Unknown a linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has the funeral director, page 2 autopsy performed' death? 1 Yes 2 No this certificate 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ဂ္ 1 🗌 Yes 2 No 4 🗌 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 06-2011

State

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only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04/27/2012 PHYLLIS SCOTT 11:43 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Essex 1241 Damsel Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Min DC untry) Months 0970771954 215-66-7605 **Director** 57 Usual Residence of Decedent 28a-f show 10b. County 10a. State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral USA 21221 1241 Damsel Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4X Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Education 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ೭ Minnie Virginia Mason Robert Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1241 Damsel Road, Essex, MD 21221 John K. Savage/friend other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, MD Nat'l Memorial Pk | 05/04/2012 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 22. Name and Address of Facility Snowden Funeral Home Signature Fineral Service License eng 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Diabetes II controlled Medical resulting in death) Due to (or as a consequence of): Examiner Asthma controlled Sequentially list conditions, Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or linjury Exam that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical requires that the death certificate be Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 XNo Month Day Year Yes the: P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law cate has page 2 s autopsy performed? Yes 2 X N this certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify, 1 🗌 Yes 2 [**X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 \square Pending work n 24 hours after death re Funeral Director: A oleted filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

State Registrar 31. Date filed (Month, Day, Year) MAY 07

certifie

30. Name and address of person who completed cause of death (Item 23a) (Type,

only one 29b. Signature and tit

Deborah Dunn, 5500 Knoll North Drive, Columbia, MD 21045 82. Registrar's Signature park

3) Frifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

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		For State		State	of Marylan	•	artment of		and N	/lental Hy	giene	201	2	16431	
		Registrar 1. Decedent's Name (First	Middle I	ast)		Cer	tificate of	Deam		2. Date of De	Reg. No.		1 2	Time of Death	
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Funeral		5. Social Security Number	6	. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birl (Month, Da	y, Year)	Co	untry)	(State or Foreign	
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hours maturi dical E	Completed	Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working									16b. Kind	of Business	/Industr	,	
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and 2 Health em 27		Christine E 20a. Method of Disposition		evens Da			Ships Be	<u>11 Cοι</u>		Annapol:		21401 tion - City o	Town 9	State	
permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.		1 ☐ Burial 2 🛛 Cre 4 ☐ Donation 5 ☐	mation 3		State C	emetery, crem	cremato:			7/2012		Burni			
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Medical Examiner		resulting in death)	4	Due to	or as a consequ	ence of):	26		7	700			-	week	
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requires that the death certificate been signed by the attending physi should be detached for use as the to	by Physician/Medic	In the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown) r		nant at time of d		Other (specify) _					Month	Day	Year	
that th	y Ph	Part II. Other significant	ondition	s contributing to d	eath but not res	ulting in the u	nderlying cause g	iven in Part	1.	23e. Did to	obacco use	contribute t	o the cau	use of death?	
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ysicia is certi directe	To Be	examiner? 1 🗌 Yes 2 🗗 No	Guioai	Hospital:	Inpatient 2 🗆	ER/Outpatien	Ott	Place of Dea ner: 4 Ni		ome 5 \square Resid	dence 6	Other (Spe	cifv)		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 DM	dical Exa	hysician: To the baselurse Practitioner	sis of examination	and/or invest	igation, in my opln	ion, death of	ccurred at	t the time, date a	nd place, ar	nd due to the	cause(s)	and manner stated.	
To th Withii To th	_	29b. Signature and title of		<u> </u>		. 5-7	29c. Licens	se number				signed (Mon	h, Day, \	(ear)	
		30. Name and address of	erson wh	o completed caus	se of death (Item	23a) (Type. P	rint)	7.732	0		7. /	, /	901	σ	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ella 24,2013 Allen Stevenson PORI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lanham Inder 1 Year | If Under 24 Hrs. Prince George Doctors Community Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Director 1 🗆 M 2 🖵 F 227-30-7161 5-3-1927 Boykin, Sc or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 ☐ No Prince George Lanham MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral 20706 USA 10012 Ridge St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 **N**O 1 ☐ Yes 2 【XNo Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: black 3 ★Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier is marked other t 9 Jewish Famil $_{
m V}$ <u>nurse assistant</u> Department of Health and Mental Hygin Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shannon Allen Eliza Lenard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Parker 10012 Ridge St. Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aten Hills 5/2/2012 22 Name and Address of Facility
22 Name and Address of Facility
21 The House of Wright Mortuary & Cremation
208 E. 35th St. Wilm., DE 19802 Servi
Approximate 21. Signature Part 1. Enter the disease, or coshock, of heart failure. List on Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: Other: 잍 1 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Director: A ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral L Medical within 24 hou

To the Funer

completely fil 29a. Certifier 🗜 Certifying Physici n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Fr. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated e Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Exami only one 29b. Signatu 04-24-2012 of person who completed cause of death (Item 23a) (Type, Print) (200 ZA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 11:25A M Melvin Eugene Smith 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14311 Florance Court Montgomery Boyds 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min Month, Day, 1 / 1 9 / Country) 65 Director 124 36 2107 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Boyds 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ural", or items 23a or Examiner must be Funeral Florance Court 14311 20841 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:Black "natural" 3 - Widowed 4 - Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Navy Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jones Smith Carrie Artis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Irving-Fairley/neice MD 20841 14311 Florance Ct. Boyds Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/14/2012|Suffolk, VA 4 ☐ Donation 5 ☐ Other (Specify) Albert Horton Vet. 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Signature of Funeral Service License milell 2294 Old Washington Rd. Waldorf, MD20601 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not st only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Year Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 □√No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

BO'S

State Registrar Dr.Alikhana

back

Carrett

Hospital

Avenue,

La Plata,

MD 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Civis

MAY 0 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20/3 Evelyn Short Carrie Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death **Examiner** Prince Georges Lanham Doctors Community Hospital 9. Birthplace (State or Foreign Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 577-46-7370 86 **Director** 10/24/1925 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 X Yes 2 No Md. Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 13107 Christie Place death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner m 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Short, within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify X Widowed 4 □ Divorced Specify: Completed Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) the Cafeteria Manager 0 Local Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Warren Mamie Ross permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is many injury or other traumsonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13107 Christie Pl., Upper Marlboro, Md.20774 Darlene James/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baptist Ceme May9,2012 Welcome, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bluford Funeral Service Signature of Funeral Service Licensee 20.19 MLK Ave., Washingt
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 2019 MLK Ave., Washington, D.c Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DIMBETES Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury for use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Month Year Pregnant at time of death g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PALLURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 certificate 2 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 2 🙀 No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D47604 2012 Da. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50bh AN, MATTHEW, M.D. 30 48 M/TCHELIVILLE ROAD ROAD MATTHEW MARKET MITCHELIVILLE ROAD BOWIE, MD20716 31. Date filed (Month, Day, Year) . Registrar's Signature State MAY 0 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 6, Physician/ Edmund Scalone 2012 G. 10:40 A M Medical 4a. Facility Name (if not iristitution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F 1276371929 577-34-2696 82 Italy Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ :: any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No St. Mary's Maryland| Charlotte Hall 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? **Funeral** 29449 Charlotte Hall Road 20622 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? XX Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Korean War 1 ☐ Yes 2 X No Specify: White Specify: 3x Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tile Setter Tile & Marble 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maria DiAndrea Antonio Scalone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26821 Fowler Court Mechanicsville, MD Linda Price / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem. 05/11/2012 Bladensburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA Funeral Se vice Lice 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed after death. that initiated events as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy perform 2 2 No 1 🗌 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 155155 W Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital o within 24 hours aft Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTENNIALST. LAPIATA. IKHAN AMIR M 101

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOMASI Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 89 093-28-0918 1 □ M 2 🕱 F Sept. 17, 1922 Jamaica Usual Residence of Decedent show ms 23a or 28a-f shormust be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro 1 🗆 Yes 2 🏝 No Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15439 Symondsbury Way 20774 USA or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 'natural", 3 X Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hospitals Nursing Assistant and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cordel Henry permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e John Dove 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 15439 Symondsbury Way, Upper Marlboro, MD 20774 Marlene A. Thompson-Smith 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/12/2012 Baltimore, MD 4 Donation 5 Other (Specify) Metro Crematory Beall Funeral Rome any in 21. Signature of Fun ral Servi e Licensee 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMONDA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIA BETER autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) Hospital Other: 2 1 Shipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ROBERT TURNER 9:44 A MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3607 BARRY DRIVE TEMPLE HILLS 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. (Month, Day, Year) 577-72-4927 1 X M 2 □ F **Director** Yrs 01/21/1953 WEST VIRGINIA 59 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PG TEMPLE HILLS 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? è ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 20748 US 3607 BARRY DRIVE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 Married þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: BLACK If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) GOVERNMENT Elementary/Secondary (0-12) HR SPECIALIST n and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ANNIE MAE MADDEN 2 ROBERT D. TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is 40560 KAVANAGH ROAD, MECHANICSVILLE, MD 20659 CHRISTOPHER M. SMITH/COUSIN other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5-12-12 FORT LINCOLN CEMTERY BRENTWOOD, MD e of Funeral Service Lice 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician CARDIOMYOPATHY Medical resulting in death) Due to (or as a consequence of): Examiner CORNARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical death certificate be Box 68760 s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy atter in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Pregnant at time of death 5 Other (specify) Month Day Year signed by the sid be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an Hospital or Attending Physician: The law page 2 has performed? Yes 2 X No certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury 8c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred After 1X Natural (Month, Day, Year) 5 \square Pending work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Af
ombletely filled in by the ft Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title o 29c. License number 2012 503 O

Registrar

State

5100 AUTH WAY, CAMP SPRINGS, MD 20748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

CHRYSTAL YELDELL

Registrar
DHMH 17 Rev 7/2009

State

3altimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

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32. Registrar's Signature

10 CENTER DRIVE, BETHESDA.

MARYLAND 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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KENNETH E.

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mode Physician/ Irving Arthur Toms Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) April 7,1929 215-26-2045 83 1 X M 2 □ F Mary land Director Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notition once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Frederick Smithsburg 1 ☐ Yes 2**)**☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21783 13916 Ridenour Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Printing Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Velma R. Lewis Henry C. Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13916 Ridenour Rd. Smithsburg, Md. 21783 Esther V. Toms (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Foxville, Md. Bethel Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg Md. MO1414 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Phusician/ SLasa disease or condition resulting in death) Loronary Medical Due to (or as a consequent e of) Examiner Sequentially list conditions, if any, leading to immediate outse. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed after death.

Director: After this certificate 1 Yes 2 No 1 Yes 2 funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 1060396 15 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURSHED 32. Registrar Signat State Registrar

Medical

Examiner

Completed by Physician/Medical

Be

Medical Certificate: To

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29b. Signature and title of certifier

Director

Funeral

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Completed

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Physician/

Medical

Examiner

Funeral

Director

28a-f show

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For State Registrar		State of M	laryland / Depa Cer	artment of I tificate of I			ene g. No. 201	2 1664
1. Decedent's Name		,	T7!			2. Date of Death May 2,	2012 Year	3. Time of Death
Elain		P.	Vanio			1		4:28 р м
		e street and number)	Rehab. Ctr.		r Location of Death		4c. County of Dea	
. Social Security Nu	umber 6. 5	Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g. Bir	thplace (State or Foreign
086-50-45	090	□ M 2 X F	55 Yrs.	Months Days	Hours Min.	12-15-13	956 Sou	th America
Jsual Residence of 0a. State	10b. County		10c. City, Town or Loc	cation	··			10d. Inside City Limits
Md.	Howar	rd	Columbi	a				1 🔀 Yes 2 🗆 No
0e. Street and Num				10f. Zip Code		10	g. Citizen of What Co	ountry?
11460 1	Little Pa	tuxent Pk		210			Guyana	
Marital Status Marrial Status	ied 2 Married	12. Was Decedent	?	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
3 Widowed		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify: Bl	ack
(Spe	15. Decedent's E cify only highest g		(Give A		during most of work	king 1	6b. Kind of Business	Industry
Elementary/Seco	onday (0-12)	College (1-4 or	5+)	NOT use retired)	nistratio	on l	Private	
7. Father's Name (F	First, Middle, Last)					ne (First, Middle, Ma		* * * *
Comptor	n	W.	Vanier		Lynett	æ	Vickerie	
9a. Informant's Na				_			City or Town, State, Zi	
Lynette I Da. Method of Disp		- Mother			Street,		, New York	
1 🗆 Burial 2		Removal from State	20b. Place of Dispose cemetery, crem Riverdale	natory or other place			Oc. Location - City or Riverdale,	Maryland
1. Signature of Fur	neral Service Licen	See Day				-	or II Fune e Plains,	eral Home Md. 20695
	rt failure. List only o Final	one cause on each lir	ed the death. Do not enter ne. WOSUENS is a consequence of): E Conon	_	_			Approximate Interval Between Onset and Death
esulting in death)	ſ	Due to (or as	a consequence of):	. <	0/0	. 0		Itours
Sequentially list conf any, leading to im	nmediate	b. Due to (or as	a consequence of):	any	14440	June		77 00 725
cause. Enter Under Cause (Disease or i that initiated events	iinjury	c						
esulting in death) L	Last	Due to (or as	a consequence of):					
	•	d						
FEMALE: 3b. Was decedent in the past 12 r 1 Yes 2 G 9 Unknown	months?		2 Fetal death 3 at time of death 5	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
art II. Other signif	icant conditions	contributing to death	but not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ENLES	halopa	Thy				1 🗆 Yes	3 □ No 3 □ F	Probably 4 🛣 Unknown
Cereb-	ral in	Fundion	, a cute			24a. Was an		topsy findings available completion of cause of
			ncy Virus			autopsy perform 1 \square Yes 2'	ed? death?	s 2 X No
5. Was case referre					ace of Death (Chec			
1 🗆 Yes 2 🌶	No	-	tient 2 ER/Outpatien		4 A Nursing H		ce 6 Other (Spec	cify)
 Manner of Death Natural Accident 	5 Pending Investigation		ury 28b. Time of injury	28c. Injur worl M 1 □	yat ⟨? Yes 2 □ No	28d. Describe how	injury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined	28e. Place of In	jury - At home, farm, stre tc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	Certifying Phy	rsician: To the best of iner: On the basis of	f my knowledge, death o	occured at the time	, date and place, a	nd due to the cause at the time, date and	e(s) and manner as st place, and due to the	ated. cause(s) and manner stated

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after death.

To the Funeral Director; After this certificate

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Worlky

Hyattsville, Maryland 20781 Dr. Paul Devore 4203 Queensbury Road,

31. Date filed (Month, Day, Year) **MAY 0 8 2012**

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D01852

29d. Date signed (Month, Day, Year)

3

2012

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Regina Ahtoy Henderson Vines 2012 7:35 A. M MAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton 8. Date of Birth (Month, Day, Year)1951 Social Security Number 6 Sex Birthplace (State or Foreign Country) . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Director 579-72-6967 60 1 🗆 M 2 🗶 F November 25, Washington, D.C. 28a-f show aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 X Yes 2 No Maryland Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 6505 Marlboro Pike 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black. White, etc. 1 Never Married 2 Married δ 2 X No Yes Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: **Black** If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DIAC Company Librarian 1 year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Dwyer Elizabeth Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 Patricia Oleana Vines (Daughtet) 6505 Marlboro Pike; District Heights, Maryland Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory, Inc. Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signature of Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): fo the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Records, P.O. Box 68760 as 1 IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) jo in the past 12 months?
1 Yes 2 No Month Year Dav Pregnant at time of death the Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 Other: 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. Ineral Director: After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201210:55P Steven Michael May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7001 Kipling Parkway District Heights Prince George's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 578-54-7410 Director 1 X M 2 □ F 67 6/20/1944 Washington DC Usual Residence of Dec shov at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director notified 28a-1 Maryland| Prince George's District Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 7001 Kipling Parkway 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 27 is marked other than "natural", or ite traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ? is marked o 1 and 2 should be fi of Health and Mental item 27 is marked ပ Thomas Michael Wood Hazel Raines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Virga Wood/Wife 7001 Kipling Parkway, District Heights, MD20747 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 5/3/2012 Edgewater, Maryland 21. Signature uneral Service Lipense 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter of disease, or complications that conshock, or hear failure. List only on cause on ear e d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Rectal Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 E FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day ed by the at detached for Pregnant at time of death Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) filled in by the funeral e Hospital or Attending Pi 24 hours after death. e Funeral Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2

Registrar DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Joselyne Kouerchou, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 04 2012

Jocelyne Kouatchou, M.D. 4041 Powder Mill Road, Suite 600, Calverton, MD 20705

D63 748

29d. Date signed (Month. Dav. Year)

May 3, 2012

Carolyn Williams	State of Maryland / Department of Health and Mental F		
Jaiotyn Williams	1- For State Certificate of Death	Reg. No.	12 1641
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Medical Examine	Carolya Williams	Month Day Year May 14, 2012	0713 hrs
7	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		th
	301 Willow Drive Elkton	Cecil	- II II (O) I
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi Months Days Hours Mi	n. Fore	ign _ 1
Birector	331-40-9039 10 M 2VF 59 Yrs. Worlds	4121953	ountry) De awar
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
*	Maryland Cecil Elkton		1 Yes 2 No
the Maryland a or 28s-f show	10e. Street and Number 10f. Zip Code	10g. Citizen of What Co	untry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f also or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	301 Willow Drive 21921	USA	
er death with i , or items 233 r must be not Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2} \text{ Status} \text{ 13. Was Decedent of Hispanic Origin?}		rican Indian, Black,
death or ite	1 Yes 2 No	to Rican, etc.) White, etc.	1
s after real", ainer	3 Widowed 4 Divorced of Page 1 Yes 2 No specify:	Specify: B	lack
hour Frant	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		/Industry
136 hin 72 than stical	12 Child Care Aide	6	lamo
5-0036 led within 72 hours Hygiene. the Medical Exan Completed		ne (First, Middle, Maiden Surname)	lome .
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than neumatic event, the Medica To Be Comple	Joseph William Archie Sr. Heler	Behecca B	errv
D 21 Dould Mend Mend Mend Mend Mend Mend Mend Men	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		e, Zip C de)
, MD 21215-0036 and 2 should be filed within 72 hours at teath and Mental Hygiene. traumatic event, the Medical Examin To Be Completed by	Helen COOK/Sister 1914 Linfield Rd N	7 000711	11.3
ore, salan of Hea If itel	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c, Location - City of	r Town, State
Page Page ment of	4 Donation 5 Jother Specify: Haven Crematory 5	25/12 Chesterton	eiship, PA
Baltimore, ML permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other traum.		ongo Funeral Hom	e 10510
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest shock or heart	Approximate Interval
Physician /Medical	failure. List only one cause on each line.	•	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	156	Bodon
	Sequentially list conditions, b		
ner	if any, leading to immediate Due to (or as a consequence of):		
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
	d.		
). Box 68760, the death certificate be executed the attending physician and ched for use as the burial - tra Physician/Medical	MENDED 23a,pt.II,27,per me,g927 5-29-	·12 sm	
Box 68760, e death certificate be centificate to the attending physiciate for use as the buriare flysician/Medii	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	23d. Date of delive	•
ox 687 eath certifit attending for use as the	past 12 months?	nancy Month	Day Year
30x death ne atte I for u	1 Yes 2 No 9 V Unknown 9 Unknown		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
Records, P.O. The law requires that to ficate has been signed by page 2 should be detac. Completed by F.	Diabetes Mellitus	1 Yes 2 No 3 Pro	bably 4 🗹 Unknown
ords, I			utopsy findings available completion of cause of
Reco		performed? death? 1 ✓ Yes 2 No 1 ✓ Y	_
	25. Was case referred to medical 26. Place of Death (Check		
ion of Vital Records, treading Physician: The law requir leath. tor: After this certificate has been so the funeral director, page 2 should I the funeral Green attor.	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursi	ing Home 5 Residence 6 🗸 Othe	ar: Scene
ing Pl After Juneral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division o spital or Attending nours after death. nearal Director: Aft filled in by the fune Certification:	1 Natural 5 Pending 2 Accident Investigation		
ivis lor A after a Direc din by	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	ural Route Number, City
Division ospital or Attent hours after death meral Director: y filled in by the Certificatic	4 Homicide determined (Specify) 29a. Certifier (Castrillo District Control of the Control of th	I	
2 E E E	check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as sta at the time, date and place, and due to t	ted. he cause(s)
To the within To the comple	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Me	
	Dan Russland ma	May 15, 2012	
	30. Name and add/ess/of person who completed cause of death (Item 23a)		
	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Balt	imore, MD 21223	
State	31. Date filed (Morth, Pal, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5, 2012 8:20 A KAREN WHITEHEAD MAY 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 6600 SUITLAND ROAD PRINCE GEORGE SUITLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y NOV • 30) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 ⋤ F VIRGINIA 224-80-4556 57 1954 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location MARYLAND PRINCE GEORGE SUITLAND 1**X**Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 SUITLAND ROAD 20746 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: BLACK BLACK If Yes, Give Year or Dates: 3 ☐ Widowed 4 K Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 Elementary/Secondary (0-12) College (1-4or 5+) BUDGET ANALYST GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES ARTHUR WHITE INEZ WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SEAN LOVELL WHITE (SON) 5 LAKEVIEW DRIVE HEATHSVILLE, VA 22473 20c. Location - City or Town, State 20a. Method of Disposition Date Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State CHURCH OF DELIVERANCE CEM. \5/10/2012 LANCASTER VIRGINIA 1☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility BERRY WADDY 6784 MARYBALL RD LANCASTER, VA 22503 23a Part 1. Enter the disease, or complications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Terrosc C42 Due to (or as a consequence of)

Physician /Medical Examiner

permit. Pages 1
Department of H
Important: If iten
any Injury or ott

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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or items

"natural"

d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r

1 and 2 s Health a

death

72 hours after

3altimore, Maryland 21215-0036

P.O. Box 68760,

Records,

of Vital

Division

or Attending Physician:

death.

hours a er

After thi funeral

filled in by the

Certification:

Director

Funeral

þ

Completed

Be

ပ

other traumatic event, the Medical Examiner must be notified at

The law requires that the death certificate be executed

Examiner burial-transit physician s the burial attending p signed by the a d be detached for need this certificate has al director, page 2 s

To the Hospital within 24 hours a

Physician/Medical þ Completed Be ၉ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner? 1 ☐ res 2 ☐ No

27. Manner of Death

1. Natural

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

that initiated events resulting in death) Last

IF FEMALE:

Medical State

Due to (or as a consequence of): Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 ☐ Yes

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ∏No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

autopsy nerformed 2 No

who completed cause of death (Item 23a) (Type, Print)

3001

and manner stated

5 Pending investigation

6 Could not be

determined

Registrar's Signature

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Year

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mo05-03-2012 9:30 A M John Edward Wooster Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Hartley Hall Nursing and Rehab Pocomoke City 5. Social Security Number Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ₹M 2 □ F Days Hours 08[™]0′9 [™]1 9°27 Director 215-20-2277 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD Pocomoke City 1 X Yes 2 No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Central Ave. 21851 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 X Yes 2 No þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 1951-1952 Specify: WHite Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Technician Government Be Department of Health and Mental Hy Important: If item 27 is marked other any injury or other transment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Costen Wooster Mary West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Atkinson/P.R. 907 Cedar St., Pocomoke City, MD, 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State First Bapt. Church Cem. 05-10-2012 Pocomoke City, MD Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home P.A. 107 Vine St., Pocomoke City, MD, 21851 ean 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ousel and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): burial-Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Garden in the past 12 months? 1 Yes 2 No 9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signed 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed Yes 2.2 1 Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after déath. Funeral Director: A 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🚰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

BA5+1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Varket

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 3, White May 3:33P Kay Η. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 22601 Wildcat Road Montgomery Germantown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 579-46-9106 Director 1 🗆 M 2 🕱 F 78 Feb. 6, 1934 Washington, D.C. Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified 28a-f 1 🗆 Yes 2 💢 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be Funeral 22601 Wildcat Road 20876 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 0 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working ed other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) of Health and Mental Health is the second or other traumatic every ည Cathryn Sagrario George Warren Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington W. White III - Husband 22601 Wildcat Road, Germantown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Metropolitan Crematorium 5/4/12 | Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Filheral Service Linense Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 over 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Injufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or -trar and Due to (or as a consequence or resulting in death) Last burialattending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Pregnant at time of death Unknown 5 Other (specify) the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 N after death.

Director; After this certificate! 2 🗆 No funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) LU Mar ell D47682 May 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 Bennett T. Morrison, M.D. 2901 Olney-Sandy Spring Road, Olney, Maryland 20832 32. Registrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marie E. Williams aM Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Plata a If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 197–32–8008 Age (In yrs. last birthday) 69 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 💆 F Hours **Director** 09-02-1942 Newport News VA 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director PA Philadelphia Philadelphia 1X Yes 2 □ No permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or? 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4253 N. 9th Street 19140 U.S. . Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 **X** No Black 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 If Yes, Gir 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Receptionist Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Waverley Nelson Thomas, Sr. Pearl Edna Tynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5108\ Alfred\ Drive,\ Waldorf,\ MD\ 20601$ Anthony R. Williams (son) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) 5-11-2012 Philadelphia, PA Chandler Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 2506 Concord Pike, Wilmington, DE 19803 CC0283 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Dancreatic cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) DS the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 No 1 Yes ours after death.

eral Director: After this certifice filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗙 No မှ 1 Phopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 K Natural 5 Pending iniury ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie much 069566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Garrett Avenue, La Plata, MD 20646 Ivelisse Michel, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 03, 20:22 HELEN V. WISEMAN Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro PRINCE GEORGE'S 5605 S. Marwood Blvd. #437 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 577-50-7562 1 🗆 M 2 🏋 F 74 1937 MARYLAND May 09, Usual Residence of Decedent 28a-f show with the Maryland aţ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 x Yes 2 No Upper Marlboro Md. Prince Georges 9 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Examiner must be items 23a Funeral 20772 United States 5605 S. Marwood Blvd. #437 death 12. Was Decedent Ever in U.S. Was Deceue.
Armed Forces?
Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. , or þ 1 Never Married 2 ☐ Married 1 Yes If Yes, Giv Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Black Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Private permit. Page 1 and 2 should be filed withi Department of Health and Mental Hygiens Important. If item 27 is marked other th any injury or other traumatic event. The the Housekeeping 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucy Bruce IInk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blount / Daughter Adrian 570 Bellerive Rd. #324 Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Spegify) Crematory 5-10-12 Riverdale Park, Md. Park Signature of Funeral Service Li 22. Name and Address of Facility

Alexander S. Pope / P
5538 Mariboro Pike/P Forestville, Md. 20747 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ haeas disease or condition resulting in death) Coronen Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) executed the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death page 2 should be detached the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 🗌 DOA this Manner of Death s after death. 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHAZALA SHAH, M.D.

Registrar
DHMH 17 Rev 06-2011

State

BRANCH AVE,

7700 OLD BRANG
31. Date filed (Month, Day, Year)

CLINTON, MD 20721

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 5, 3. Time of Death Physician/ Raymond R. Weeks, Sr. а м May 9:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Health Care Bradford Oaks Clinton Prince George 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **Director** 1**X** M 2 □ F 215-26-0539 82 Dec. 18, 1929 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Charles Indian Head 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code .s 23a o. c must *b* 10a. Citizen of What Country? Funeral 25 Glymont Road 20640 U.S.A. items Page 1 and 2 should be filed within 72 hours after death [,] ment of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or ite the Medical Examiner Black, White, etc. by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify. Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) ed other event, th Electrician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H မ Albert Weeks Susie Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond R. Weeks, Jr. Son t: If item 2 18 Glymont Rd., Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 14, 2012 Department of Important: If any injury or Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 21. Signature of Funeral Service Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart ailure. List only one cause on each line shock. Immediate Cause (Final Physician/ disease or condition resulting in death) CHRMIC OBSTANTUS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year signed by the a 1 Yes 2 9 Unknown 2 🗌 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown After this certificate has been significate has been significated and After Af 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 № Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Prospital or Attending P 24 hours after death.
Funeral Director: After the Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifie 📯 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗆 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rond Fort working has 1.) DANG MI 1701 Livingsh

Registrar

31. Date filed (Month, Day, Year)

MAY 0 7 2012

	1	State of Maryland 1 - State Registrar 1. Decedent's Name (First, Middle, Last)		rtificate of l	Death	Re	g. No. 201	2 1645
Physicia /Medica	n	ALZATA E. M. WRENN			A	PRIL 26	, 2012 Year	10:12 A ^M
Examine		4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital			Location of Death		4c. County of Dea	
uneral irector		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Report of the Hours Min. A	B. Date of Birth (Month, Day, ugust 2	9. Bit O Au	rthplace <i>(State or Foreign</i> ountry) gusta, Ga.
MOI 12		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Event and the nutified at once. To Be Completed by Funeral Director	cto	Maryland Prince Georges Ft.	Washi	ngton				1 ⊈Yes 2 □ No
	Dire	10e. Street and Number 520 Roundtable Dr.		10f. Zip Code 20744	,	10	g. Citizen of What C	
	nera	11 Marital Status 12. Was Decedent Ever in U.S.	13.		t ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	United St	erican Indian,
	by Fu	Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes 2√k No	Specify:	ican, etc.)	Black, Whi	·
	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of working	, 1	6b. Kind of Business	·
	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		cretary	"/		Federal (Government
	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name			
- -	٥.	Clinton Moss 19a. Informant's Name/Relationship (Type. Print)	10h Maili	ng Address (Street	Susie A			Zin Code)
		Ilean Dixon/ Sister			le Drive,			• •
		20a. Method of Disposition 1 ဩBuriai 2 ☐ Cremation 3 ☐ Removal from State 20b. Pla		osition (Name of matory or other place		te 2	Oc. Location - City o	r Town, State
		4 □ Donation 5 □ Other (Specify) MD V			ery 5-3-2	012 (Cheltenham	n, MD
NIIA.		21. Signature of Funeral Service Mensee	2:	2. Name and Addre Alexander 5538 Mart	ss of Facility : S. Pope .boro Pikė	PA	ville Md	l. 20747
sician edical miner		23a. Part. Enter the diseale, or complications that caused the death.		Approximate Interval Between				
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		Onset and Death				
		Due to (or as a conseque		i. CAR	NACH CYC	tevu	disease	
١	ے اور	Sequentially list conditions, if any, leading to immediate b. Atherosclerotic coronary artery Due to (or as a consequence of):						<u> </u>
ľ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
		Due to (or as a conseque	nice or).					
	ledic	d.		,,,				
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown		23d. Date of do Month	elivery Day Year			
	by Pr	Part II. Other significant conditions contributing to death but not resulting	ing in the u	nderlying cause giv	en in Part I.	acco use contribute to the cause of death?		
	ted	Hypertension (2)		O		1 ☐ Ye	s 2 No 3 I	Probably 4 Unknown
	Completed	Congestive Meave 1	estive Heart Failure					
	ပိ	25. Was case referred to medical			26. Place of Death	perform 1 Yes 2		es 2 No
Ш	9	examiner?	R/Outpatie	nt 3 DOA Oth	or.		nce 6 ☐ Other (Sp	ecify)
ľ	iio	27. Manner of D ath 1 28a. Date of Injury (Month, Day, Year) 28a. Date of Injury (Month, Day, Year)	8b. Time o Injury	Wor	k?	3d. Describe how	w injury occurred	
	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom	Yes 2 □No	28f. Location (Street and Number or Rural Route Number,				
	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	r. Location (Street and Number of Hural Houte Number, City or Town, State)				
	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examinating and manner stated.	ause(s) and manner ate and place, and du	as stated. ue to the cause(s)				
	ž	29b. Signature and title of pertition		29c. Licens		29	Od. Date signed (Mor	01 - 0
	-	30. Name and address of person who completed across of death //tom 5			16741		Moral	20744
		30. Name and address of person who completed cause of death (Item 2) Deepa K Sachdeva, M.D. 11		Livinas	ton Rd. F	out Wa	ashinata	n MD
Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signatu AAY 0 8 2012	re de la constitución de la cons		The state of the s			1 000
gistra		SHI O COLE PERSON No. 17	-					
ev 1/20	UT							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

16450

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2012 JOYCE PEARLNETTE WILLIAMS 20:16 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2611 LUANA DRIVE #303 FORESTVILLE PG 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days (Month, Day, Year) Months Hours 577-58-2850 **Director** 1 - M 2X F 08-17-1944 67 VA Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MD PG FORESTVILLE ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 2611 LUANA DRIVE, #303 20747 US death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 'natural", 3 Widowed 4 Divorced Specify: Completed BLACK Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12TH NURSING AIDE DC GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 2611 LUANA DRIVE, #303, FORESTVILLE, MD 20747 NATHANIEL WILLIAMS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State jo 1 XBurial 2 Cremation 3 Removal from State Department o Important: If ò HERITAGE MEMORIAL MAY 7, 2012 WALDORF, MD injury o 4 Donation 5 Other (Specify)/1 Signature of Funeral Service Licen 22. Name and Address of Facility FOPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listoply one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCUSACTIC HEART DISCUSE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Districto (or as a constituiring of) cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Por in the past 12 months?
1 Yes 2 X No Pregnant at time of death g Unknown g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? , HYPERTENSION, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown PERIFERAL ARTERIAL DISCAS 24a. Was an 24b. Were autopsy findings available autonsy prior to completion of cause of death? 1 Yes 2 No Yes 25. Was case referred to medica filled in by the funeral director Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Accident
Suicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 within 2 To the I only one) 29b. Signature ap 29d. Date signed (Month, Dav. Year) D0068418 2012 ents

DHMH 17 Rev 06-2011

State Registrar 1221 MERCANTILL EN, CARGO, MID 2074

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month pri Physician/ Walker 0545 Pearl 28, 201 Hattie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince Georges Southern Maryland Hospital If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In vrs. last birthday) Year If Under 24 Hrs. **Funeral** Months Hours 577-56-2646 **Director** 1 M 2 X F Dec. 5, 1939 Georgia 72 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f shominer must be notified at 10a. State Director 1X Yes 2 ☐ No MD PG Fort Washington 10e Street and Number 10f, Zip Code 10g Citizen of What Country Funeral United States 20744 3106 Rose Valley Drive death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterr ledical Examiner n 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Yes Give 3 Widowed 4 Divorced Completed Black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) 12 College (1-4 or 5+) Nursing Assistant Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or and nd Mental F Albert Shank Hurley Hattie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 Rose Valley Drive Washington, MD. 2 Cleveland Walker/husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 5/9/12 cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Mem. Cemetery Suitland, MD & Edwards F.H. 22. Name and Address of Facility Hodges Signatur of Funeral Service Licenses Suitland, MD. 20746 3910 Silver Hill Rd., 71. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANCREAT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 as the l ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ate has been signated based and based and based are seen signatured based are seen signatured based and based are seen signatured based are seen Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b Time of Certificate: 28d Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day,

8 2012

32. Registraris Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item = For State Registrar #1, per physician, 5/14/12, Certificate of Death E.T, WCHD 1. Decedent's Name (First, Middle, Last) Doris Gloria Xavios 2. Date of Death 3. Time of Death Physician/ Year Doris Gloria Xavois Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENIN SULD REGIONAL MASICAL Cento HIGOM SALISBUIL Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 177-24-4891 1 M 2 XF 80 7/20/1931 PAUsual Residence of Decedent or 28a-f show 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12534 Old Bridge Rd. 21842 USA "natural", or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. 3 X Widowed 4 □ Divorced Specify: Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 12 Owner/Operator Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ralph Gasser Viola Rissmiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Donna Brittingham/daughter 12534 Old Bridge Rd., Ocean City, MD Baltimore, Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 injury or 1 Burial 2 Cremation 3 Removal from State 5/12/2012 Speis Cemetery 4 Donation 5 Qther (Specify) Alsace Twp., Signarre uner ervice Licen 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter Approximate Interval Between Immediate Cause (Final Onset and Death Physician[®] ERKPIDGENIC disease or condition resulting in death) SHOL Medical Due to (or as a consequence of) Examiner INFERIOR YOCARDIAL Sequentially list sonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ASTUD the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be Box 68760 use as t IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death detached Unknown Division of Vital Records, P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 1 Yes 2 X No 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of After t 28c. Injury at work? 28d. Describe how injury occurred injury 1 Matural 5 Pending 1 Yes 2 No after death Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier innis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 4, 2012 8:00 A M Ernest Young Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospice of Chesapeake Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, Year) 247-44-6918 **Director** 1 X M 2 □ F 82 Aug. 15, 1929 DC Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Lanham Prince George's Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with items 23a Funeral 5400 Barbara Drive 20706 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify. Black Specify "natural" Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me onee. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5th Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rose Mae Welldon Ernest Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest Young III - Son 15161 Robbers Roost Court Waldorf, Md. 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
Hill Cedar
Hing Cemetery May 12. 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Suitland, Maryland Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John T. Stewart 4001 Benning Road NE 20019 Washington, DC M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician disease or condition resulting in death) <u> Alzhimers Disease</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Examir Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Pregnant at time of death 2 No the a 9 Unknown g 🗌 Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Multiple Deep Venons Thrombosis 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2X No has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital Other: Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury after death. 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) 24 hours Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

29b. Signature and

Thomas E. Maslen

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Drive

29c. License number

D55559

Suite 312

29d. Date signed (Month, Day, Year)

20770

May 8, 2012

Greenbelt, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel 2646 Shadow Cove 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 215-48-6718 1 🕅 M 2 🗆 F 58 Yrs. 11/26/1953 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits
1 Yes 2 No Annapolis Maryland Anne Arundel

10g. Citizen of What Country?

14. Race - American Indian,

White

Black, White, etc.

United States

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

Jeannette Gowans

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2646 Shadow Cove, Annapolis, Maryland 21401

Date

05/08/2012

16b. Kind of Business/Industry

Commercial A/C

20c. Location - City or Town, State

Edgewater, Maryland

Onset and Death

24b. Were autopsy findings available prior to completion of cause of

1 ☐ Yes 2 ☐ No

10f. Zip Code

16a. Decedent's Usual Occupation

life. DO NOT use retired)

Steamfitter

20b. Place of Disposition (Name of cemetery, crematory or other p

21401

1 ☐ Yes 2 X No Specify:

(Give kind of work done during most of working

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Medical **Examiner Funeral** Director 28a-f show the Maryland at Director notified ò er than "natural", or items 23a of the Medical Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with i Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b Funeral Completed by Baltimore, Maryland 21215-0036 Be ည

Physician/

= State Registrar

10a. State

10e. Street and Number

11. Marital Status

2646 Shadow Cove

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 Widowed 4 X Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

William B. Yates, Jr.

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

Jeannette G. Yates/Mother

20a. Method of Disposition

1 Burial, 2 X Cremation 3 Removal from State

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

College (1-4 or 5+)

If Yes Give

Year or Dates

Physician/ Medical Examiner

attending physician

peen

has

after death.

Director: After this certificate

within 24 hours a To the Funeral Completely filled

To the Hospital or Attending Physician:

The law requires that the death certificate be

P.O. Box 68760

Division of Vital Records,

use as the burial-tran signed by the at Id be detached for Should page 2 s funeral director, filled in by the

Exami Physician/Medical ð Completed To Be Certificate: Medical

(Check

3 Certifying Nurse Practitions

22. Name and Address of Facility George P. Kalas Funeral Home 21. Signa 2973 Solomons Island Road, Edgewater, MD 21037 23a Part Enter the disease, or complications show, or heart failure. List only one cause Immediate Cause (Final disease or conditions) hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. OLON disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural Accident 5 Pending iniury work? 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 06-2011

10

State Registrar death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 2 6 5 6	1 - For State of Maryland State of Maryland						
2. Date of Death Month Day Year 3. Time of Death May 3 2012 8:23 P M	1. Decedent's Name (First, Middle, Last) Physician/ Medical Mary Mandris Zuras						
4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel	Examiner 4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center						
Months Dave Have Min 18 18 18 18 18 18 18 18 18 18 18 18 18	Funeral Director 5. Social Security Number 216–18–5837 Usual Residence of Decedent 6. Sex 1. M. Age (In yrs. Ia. 90)						
Annapolis Annapolis 10d. Inside City Limits	Toe. Street and Number						
10f. Zip Code 10g. Citizen of What Country? U.S.A.	We street and Number 10e. Street and Number 1152 Summit Drive 11. Marital Status 12. Was Decedent Ever in L						
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XXIo Specify: Specify: White	Armed Forces?						
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) THE CONTROL OF THE	Solution with the property of						
Administrative Assistant U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) Dora Tongalos	The continue of the continue						
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1152 Summit Drive Annapolis, Maryland 21409	Nicholas Zuras/husband						
Place of Disposition (Name of cemetery, crematory or other place) ate of Heaven Cem. 5/15/2012 Silver Spring, MD	20a. Method of Disposition 20b. Place 20						
22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401	21. Sign III Theral Selving Icenses						
ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Myocardial						
on	Examiner Hypertension						
dism	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions). Due to (or as a consequence of the conditions). Due to (or as a consequence of the conditions).						
rtery Disease	o e d at the control of the control						
tal death 3 Dectopic pregnancy	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Ar						
	The state of the s						
1 Yes 2 No XXProbably 4 Unknown 24a. Was an autopsy prior to completion of cause of	Pulmonary Embolism Pulmonary Embolism						
performed? death? 1 Yes 2 XXIvo 1 Yes 2 No 26. Place of Death (Check only one)	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital:						
ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 28d. Describe how injury occurred	25. Was case referred to medical examiner? 1 Yes 2XXNo Hospital: 1 XXnpatient 2 E						
injury work? M 1 □ Yes 2 □ No	27. Manner of Death WX Natural 2 Dending Investigation 3 Suicide 4 Homicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Place of Injury - At hom building, etc. (Specify)						
(fy) City or Town, State)	The state of the s						
wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my						
29c. License number D0056088 29d. Date signed (Month, Day, Year) May 4, 2012	오를 요 항 29b. Signature and the of certific						
n 23a) (Type, Print) ie Highway Arnold, Maryland 21012	30. Name and address of person who completed cause of death (Item 2 Dr. Lisa Keithley 1509 Ritchie						
A. Jane	State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signatu MAY 0 8 2012						
ie Highway Arnold, Maryland 21012	Dr. Lisa Keithley 1509 Ritchie						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#19b Per FH G927 5/29/2012 JH
State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:05 PM Geraldine 20 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 X ۷A JUNE 7,1949 **Director** 219-52-7589 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 10a State 10b. County 1 XYes 2 No Director BALTIMORE TURNER STATION 10g. Citizen of What Country? 10e. Street and Number ö must be i 507 NEW PITTSBURG AVENUE Funeral 21222 USA Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced **BLACK** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRICAL CABLE SPLITTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H item 27 Is marked oth r other traumatic even JOSEPH SOMMERS LOUISE VENNIE မ or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Health a STELLA BEACH/SISTER EXMIRE, 36450 SEASIDE 23420 VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State EBENEEZER BAPT.CH.CEM. 1 Burial 2 Cremation 3 Removal from State Department o Important: If any Injury or = 5 128/12 WARDTOWN, VA 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. BALTIMORE, MD 21217 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (cr is a consequence of) 48 hours /Medical Examiner Pulmonery unknows Sequentially list conditions, if any leading to in the citic cause. Enter Underlying Cause (Disease or injury Examiner Due to jor as a consequence of): The law requires that the death certificate be executed g physician and as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Pulmonon 1 🗌 Yes 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atnal autopsy performed? ki dres 2 No Chonic 1 🗆 Yes 1 Tes certificate 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 🗆 DOA ၉ this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No death. 2 Accident s after death 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Hospital 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1811286834 201 Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanbor Monica 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 82. Registrar's Signature State NAY 2 4 2012

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Registrar

backer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg. No.											
Physici Medical Exam		Decedent's Name (First, Midd Naim Muht				2. Date of Dea Month May 21, 2	Day Year	3. Time of Death 0630 hrs					
		4a. Facility Name (if not institution St. Joseph's Hospital	n, give street and number	er)	41	o. City, Town, or Le Towson	ocation of Deat	n	4c. County of Death Baltimore County				
Funeral Director		5. Social Security Number 205-50-1320	6. Sex 7. / 1 X M 2 F	Age (In yrs. last bir 44	thday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mir			Birthplace (State or Foreign Country)			
'n		Usual Residence of Decedent											
ow any		10a. State 10b. County	10d. Inside City Limits 1 X Yes 2 No										
Maryland 28a-f show d at once.	ctor	MD N	0g. Citizen of Wha										
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shoumatie event, the Medical Examiner must be notified at once.	Il Director	1348 Washing				10f. Zip Code 2123			US	USA			
ath wi	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, o								- American Indian, Black, etc. African			
fter de	y Fu	3 Widowed 4 Div	orced If Yes, Give Year	2 X No	1 \	res 2 No	specify:			American			
ours a	d by	15. Decedent's Education (Spe-	or Dates: cify only highest grade c	ompleted) 16a.		s Usual Occupationst of working life. D			16b. Kind of Bus	iness/Industry			
36 thin 72 h e. than "n edical E	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4 o NA	or 5+)	_	scaping	O NOT use re	irea)	Landsca	ping Company			
5-00 led wit Hygien other	S	17. Father's Name (First, Middle,	Last)			18	.Mother's Name	e (First, Middle, N	Maiden Surname)				
21215-0036 and be filed within 7 Mental Hygiene. marked other than	Be	Harry	Montgome			and the same of th	Barbara		McGi				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	욘	19a. Informant's Name/Relations Barbara Clowde			6550	N. 18th	Street			, State, Zip Code) PA 19126			
or Heal		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S	State cremat	tory or othe		-"	Date		City or Town, State			
Baltimore, permit. Pages I at Department of Hee Important: If ite	4 Donation 5 Other Specify: King M							23-12		lstown, MD			
Ball permit Depart Impor injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore, 1											
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interv											
/Medical Examiner		failure. List only one cause on each line. Ketoacidosis and Bronchopneumonia complicating Between Onset a Death Death Death								Between Onset and Death			
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8760, tificate be ng physicials the buria	Ne s	IF FEMALE: 23b. Was decedent pregnant in th		ome of pregnancy			1		23d. Date of d				
Box 68's e death certifithe attending ed for use as t	iciar	past 12 months?	4 Pregnant	at time of death		rdeath 3. <u> </u>	Ectopic pregna	incy	Month	Day Year			
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Records, The law require ficate has been si	ם	autopsy prior to completion of cause of performed? death?								eath?			
tal Recian: The certificate ector, page									✓ Yes 2 No				
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To th withi: To th comp	Medical	29b. Signature and title of certifier	niner: On the basis of ex and manner stated		ivestigation	29c. License		it trie time, date a		e to the cause(s)			
		auo 57				O.C.M.			May 21, 201				
DF 45	-	30. Name and address of person	who completed cause of	death (Item 23a)	-								
Par .		Ana Rubio MD. Ass	istant Medical Exa	, ,	V. Baltim	ore Street, Ba	altimore, MI	21223					
St Regist		31. Date filed (Month. Pay Year)	32. Registr	ar's Signature									

Elizabeth Ann Bl			Sta	te of Mary	land / De	partment e <i>rtificate</i>	of Hea	Ith and	Mental	Hygiene		21	0 1	2 164	. 5
Physicia		Registrar 1. Decedent's Nam	e (First, Middle,	Last)			OI DCa			2. Date of D				3. Time of Death	
Medical Examin			Elizabeth Ann Blankenship							Month May 21	, 2012	y Year		2025 hrs	
		4a. Facility Name (if not institution,	give street and					ocation of De	ath		4c. County of Howard	f Death		
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212 212 Went be mark	ToB	19a. Informant's N	ame/Relationshi	p (Type, Print)		19b. Ma	iling Addre	ss (Street	and Number	or Rural Route	Number	, City or Towr	n, State,	Zip Code)	
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re, slanc fHeal ffiten		20a. Method of Dis	·	3 Remova		0b. Place of Dis crematory o			etery,	Date	20	c. Location -	City or	Iown, State	
Page nent o		4 Donation 5	Other Spe	cify:		rest La	awn Me	em.Gar	rdens '	5/25/201	12 M	arriot	tsv	ille. MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service	icensee			2. Name ar Lunera	nd Address a_1 Hot	of Facility St	terling Catonsv:	Ash ille	ton Sc	hwa	ille, MD b Witzke MD 21228	
Physician		23a. Part I. Enter	ne disease, or c	omplications tha	at caused the de	eath. Do not ent	1630 er the mode	Edmon e of dying, s	dson_A such as cardia	venue; ac or respiratory	cato arrest,	Shock, or hea	<u>e.</u> art	Approximate inter	
/Wedical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):												nd	
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b.O. B that the dd ned by the detached i	, Phy	Part II. Other sign	ificant condition	ns contributin	g to death but r	not resulting in t	he underlyi	ng cause g	iven in Part I.				_	the cause of death?	
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Completed										utopsy	Р	rior to c	topsy findings availa ompletion of cause	
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risic r Atter er dea irector	ficat	2 Accident 3 V Suicide			21, 2012 Place of Injury -	2000 hrs At home, farm,		ory, office b	uilding, etc.				er or Ru	ral Route Number, (City
Div ours aff	Certification:	4 Homicide	deterr		cify) residen	се				7911 Rust	n, State ling Ba	irk Court, E	llicott C	city, MD	_
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely, filled in by the funeral director, page 2 should be detached for use as the built		29a. Certifier (Check only	Certifying Phy Medical Exam	ysician: To the	best of my know	wledge, death o	ccurred at t	the time, da	te and place,	and due to the d	cause(s) and manner I place, and d	as stat	ed. e cause(s)	
To th within To th	Medical	one) 2 ✔ 29b. Signature an		and mann	er stated.	on and/or mives		29c. License					_	nth, Day, Year)	_
	2	250. Signature an	a title of certifier		m *			O.C.1				May 22, 20		,	
		30-Name and address of person who completed cause of death (Item 23a)										-			
3			exander MD.		t Medical E	xaminer 9	00 W. B	altimore	Street, Ba	ltimore, MD	2122	3			
\	tate		nth Day Year)	2012 32	. P gistrar's Sig	gnature	Barks	1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G927 5/24/2012 JH State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 3. Time of Death **08:20 P**M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Blackwell Detrou 2012 Location of Death Facility Name (if not institution, 4b. City. Town 4c. County of Death Baltimore Medical 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/26/1948 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 216-50-4236 1**X** M 2 □ F 64 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4642 Northwood Drive 21239 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status rmed Forces?

X Yes 2 \(\sum \) No 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 10th Stevadore Sparrows Point 17. Father's Name (First, Middle, Last) 18. Mother's Name First, Middle, **Brooks** Maiden Surname) Detroy Blackwell, Sr. Ruth Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Blackwell-Wife 4642 Northwood Dr. Baltimore, MD 21239 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State OwingsMills, MD 6/1/2012 Garrison Forest 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H-East 1101 E. Signature of Funeral Service Licenses North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or eroscherosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 Y death? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician/ Medical **Examiner** Box 68760 CL physician and sthe burial-trans use as ding jo P.O. signed by to

Division of Vital Records,

To the Hospital or Attending Physician: The law requires

Physician/

Medical

10a. State

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28a-f show

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should be filed within 72, and Mental Hygiene.

ge 1 and 2 sl nt of Health s : If item 27 i

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3altimore, Maryland 21215-0036

Exami Physician/Medical þ Completed Be မ funeral Certificate: within 24 hours after death

To the Funeral Director:

completely filled in by the f

25. Was case referred to medical examiner? 3 Suicide
4 Homicide

-	1 L Yes	2	No
27.	Manner of E	Death	
	1 Natura	ıl	5 🔲 Pen
	2 Appide	nt	Invo

ding Investigation 6 Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?
1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number 29b. Signature B100568

State Registrar

Medical

30. Name and address of person who complete 31. Date filed (Month, Day, Year

cause of death (Item 23a) (Type, Print)
10 North Greene St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical center tagerstown washingto 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral (Month, Day Year) Director 1 □ M 2 **X** F VA show 10c. City, Town or Location 10d. Inside City Limits Funeral Director 28a-f 1 X Yes 2 ☐ No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a21213 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event. the ****." Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roote Number, City or Town, State, Zip Code) 4108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ pertension lear. disease or condition Medical resulting in death) Examiner aisease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Immunodeficiency virus of Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown 1 Live Birth
4 Pregnant a
9 Unknown Month Day Pregnant at time of death be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy perform 20 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital ပ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) . Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) R128088 * Kate yn Smith 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21740 1126 cpal Ct. 31. Date filed (Month, Day, Year) State MAY 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mavis M. Black 14:31 May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hosp. Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 4/19/34 213-60-6336 Jamaica 78 Director 1 □ M 2 🔀 F Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits or 28a-f sh notified MD N/A Baltimore X□ Yes 2 □ No 10e. Street and Number 123 W. 29th St.-5B 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or 21218 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specifyamaican 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced intal Hygiene. ked other than "natura c event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pric. Duty Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o ဂ္ unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> item 27 104B W. 25th St., Balt., MD 21218 Winston Black/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Druid Ridge Cem. Burial 2 ☐ Cremation 3 ☐ Removal from State 5/29/12 Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs, PA 21. Signature of Funeral Service Lice 5126 Belair Rd,Balt.,MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Car dispulmonary Medical resulting in death) Due to (or as a consequence of): Examiner weeks Metabolic Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami week Sepsis use as the burial-transi Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☑ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be □ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 8 Mills - Robertson AT2438946 5/21/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East University 201 Par Kway Baltimore, Maryland 31218 EKOW Mills - ROBERTSON

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 22, Physician/ Olive Valsetta **Beck** 1:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1900 Grove Manor Road Apt 417 Essex Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Director 212 42 3233 1 □ M 2 🕱F 87 05/09/1925 Jamaica Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland 1 Yes 2 No Baltimore Essex 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1900 Grove Manor Road 21221 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Examiner Armed Forces Black, White, etc. ori Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced If Yes, Give Jamaican "natural", Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress 12 Clothing Mfg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Russell Turlough Maud Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donovan Beck Page 1 and 2 (son) 7805 Birmingham Avenue Parkville Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem Garden's 6/26/2012 Middle River Maryland Donation 5 Other (Specify) 21. Sign Service License 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack Immediate or heart failure. List on v one cause or Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): aral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No ဂ္ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural Accident iniury 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and t 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, 2300 TY State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** salungartner 140 PM 5 21 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FRANKLIN Square HOSPITa Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July21,1925 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F 86 Director 219-22-7901 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Exercitive must be notified at MD Baltimore Director 1 ☐ Yes 2 → No Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 604 Riverside Drive 21221 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self - Employed 2yrs Marine Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. Be Herman Baumgartner ည Gertrude Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lavinia Baumgartner /wife 604 Riverside Drive Baltimore MD 21221 20b. Place of Disposition (Name of Garden's Of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1X/Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Danation 5 ☐ Other (Specify) 5/25/12 Rossville MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signatu Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 □ NO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Watural To the Hosping Superior Within 24 hours after death.

To the Funeral Director: At The Funeral Director of the funeral by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide l🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (attending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
REVIN Schendel ND 9114 Philadelphia RD, Suit 300 BACTO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NAY 2 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Day 2012 May 20, Physician/ 7:30 A M Nemours Theodore Bourg Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kensington Woods Assisted Living Montgomery Kensington If Unde Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) Louisiana 1 X M 2 □ F Months Hours October 25, Yrs Director 579-20-7613 87 1924 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at death with the Maryland Director 1 Yes 2 X No Maryland Kensington Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? United States 3618 Littledale Road 20895 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner rmed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married 2 No 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced WWII the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Department of Housing and Urban Development Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government 4 traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Francés McKay Clarence Bourg Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 703 Houston Avenue, Takoma Park, Maryland 20912 James Bourg / Son 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Monit gome Ty May 24, 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematorium, Inc Robert A. Pumphrey Funeral Home, Bethesda - Chevy Chase, Inc. M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examir cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transi Dementia resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? signed by the atte Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed Yes 2 X certificate 2 No 1 Yes b Hospital or Attending Physician: 24 hours after death. 5 Funeral Director: After this certificieted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Living Other: 4 Nursing Home 5 Residence 6 K Other (Specify) Hospital: 2 1 🗌 Yes 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) Certifying 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D53691 May 21, 2012

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person

Ajay Reddy, M.D.

3200 Tower Oaks Blvd. #110, Rockville, Maryland 20852

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2012 3 = 10 PM Joshua T. Bailey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RAVEN LOCH Baltimore N/A If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Min Months Days Hours Director MD 82 214-26-3399 Oct 3, 1929 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene.

Important: If item 27 is marked other than """"

any injury or other than """" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore** MD **Baltimore City** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1217 Cleveland Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc à 1 Never Married 2 Married 1 ★ Yes 2 □ No **7/22/1955** If Yes, Give 1 ☐ Yes 2 🗷 No Specify Specify: Black Completed 3 Widowed 4 Divorced 7/13/1957 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Paper Pack Company Mechanical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joshua T. Bailey Sr. Maggie Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Cleveland Street Baltimore, MD 21230 Vanessa Shepherd 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State May 30, 2012 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) **Garrison Forest Veterans** Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (a) as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of: attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 X No prior to completion of cause of death? page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ည 1 Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number ပ 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD RAVEA LOCH

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Evelyn Ainsley Bowdle** Month May 13, 2012 Year 5:40 A M Medical 4c. County of Death **Howard** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Lighthouse Senior Living at Ellicott City Ellicott City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 4, 1921 Funeral If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Min. 315-28-3547 Ohio 91 Director 1 🗆 M 2 💢 F 28a-f show 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits notified at Director MD Howard Columbia 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 9230 Moonfire Pl. 21045 U.S.A or items 72 hours after death 11. Marital Status 12. Was Decedent Eyer in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Hygiene. other than "natural", If Yes, Give 3 Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of worn down) life. DO NOT use retired) **Supervisor** (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname)
Victoria Vaughn 17. Father's Name (First, Middle, Last) ပ **Byrd Samuel Harris** 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 9230 Moofire Pl. Columbia, MD 21045 Department of Health an Important: If item 27 is any injury or other trau once. Randy Malm son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Linthicum Chapel Cemetery Jun 09, 2012 Clarksville, MD 4 Donation 5 Other (Specify) 22. Name Stack Fine Faf Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ature of Funeral Se 23a. Part Softer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 5 Other (specify) Day Year be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 I ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Spe ER/Outpatient Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier pleted cause of death (Item Name and address 21 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 22, Physician/ 2012 1:05 AM Nancv Р. Bolton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Director 097-22-3368 1 M 2 X F Mar. 28, 1928 New York 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Parkville Baltimore Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #1410 21234 USA 8800 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KMNo Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 4 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Elizabeth Frederick S. Pease, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3087 Zumbrum Rd. Glenville, Pennsylvania 17329 Ellen B. Kohr/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 5/23/12 Hilltop Serice Corp. : |Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Debilita Physician/ disease or condition Medical resulting in death) quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗷 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 KOther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) AS MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0/ N Charle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 Month Physician/ 13 2012 ea Rodney E. Bellamy 4:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Baltimore N/A Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours 54 0696477957 254-98-3733 Alabama Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hart: If item 27 is marked other than "natural", or items 23a or 28a-f show lony or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐√Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1305 Kitmore Rd. 21239 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 2**X** No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) years Security Guard Securitas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Willie Bellamy John Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Bellamy(wife) 6101 Hemlock Ave., Gary, IN 46403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory 05/17/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ²ට්ර්පීම්ච්ර්්ර් සි of FBrown Jr. Funeral Home PA trich N 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗌 No 2 1 1 Yes Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: မ 1 Tes 2 N/0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUMAR N CHARLS SUITE 4105 led (Month, Day, Year)
MAY 2 4 2012 Date filed (Month, Day, State Registrar

/ DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Reg. 75,27,28a-f per me, g927,05/23/2012dhb Reg. No. For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2012 Year Augie Marshall Campanello 5 9:35 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Days Hours 235-92-4866 Director 1 XXM 2 🗆 F 55 Jan. 21,1957 Virginia Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location Examiner must be notified at Director DC Washington D.C. 1XXYes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 3315 Wisconsin Ave. NW 20016 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XXVo 21215-0036 1 Yes 2XXNo Specify: White Completed 3 Widowed 4 XXDivorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) College (1-4 or 5+) V.P. Marketing Administration Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Augustine Campanello The 1ma Thomason Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David B. Johnston / Brother 103 Hillcrest Dr., Bluefield, VA 24605 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 04/10/2012 Beltsville, MD 21. Signature of Funeral Ser 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00982 20910 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ CARDIOPULMONARY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ACUTE RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury SEPSIS that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): CERTIFICATI Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. PNEUMONIA Box 687 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TETRAPLEGIA Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' death? 1 Yes Yes 2 No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 X Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending **Unknown**^M 1 Yes 2X No XAccident 12/20/2011 Subject fell Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Unknown Unknown Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check critifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tipe of certifie 29d. Date signed (Month, Day, Year)

(2)

7:35AM

2012

051

7

Campanello,

Registrar

DHMH 17 Rev 06-2011

10110 MOLECULAR DR. #206, ROCKVILLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARICHU MATAS M.D.

31. Date filed (Month, Day, Year)

ly (le

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department		/lental Hygi		0 16171
				rtificate of Death	Re	g. No. 201	2 64/
	Physicia		1. Decedent's Name (<i>First, Middle, Last</i>) Helen Carter		2. Date of Death Month May	22 2012	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	l lidy .	4c. County of Deat	10:50 A M
			MD Masonic Homes	Cockeysville		Baltimor	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 578-03-4725 77. Age (In yrs. last birthday) 77s.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth _(Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign untry)
1	Director		578-03-4725 1 M 2 X 98 Yrs.		July 21	1913	MD
	land shov d at	tor	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary 28a-1 otifie	irec		ysville			1 ☐ Yes 2√√ No
	ith the 3a or t be r	ralD	10e. Street and Number 300 International Circle	10f. Zip Code	10	g. Citizen of What Co	untry?
	ems 2	Funeral Director		21030 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ame	rican Indian
٩	ter de , or it		I 1 □ Never Married 2 □ Married I 1 □ Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
200	urs af tural" al Exa	ted	Year or Dates.	1 ☐ Yes 2 🔀 No Specify;		Specify: wh	ite
င်	72 hc n "na Nedic	Completed by	(Specify only highest grade completed) (Give)	dent's Usual Occupation kind of work done during most of worki O NOT use retired)	ing 1	6b. Kind of Business	Industry
7 .	within giene. er tha , the I		Elementary/Seconday (U-12) College (1-4 or 5+)	etary		Clerical	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
₹	uld be d Men narke natic	-	John Kirby Martin	•	/anValken		
⊠ S	2 sho Ith and 27 is r traur		l 	Gouth Manaharias T			,
ō,	age 1 and 2 should be file ant of Health and Mental H It: If item 27 is marked of y or other traumatic ever		20a. Method of Disposition 20b. Place of Dispo	South Marshview F		Oc. Location - City or	
Ē	Page nent o ant: If ıry or		Danial 2 de Gromation o de Homovar nom Grate	natory or other place) Cemetery 5/25/	/12 P	arkville,	MD
saltimore,	permit. Page 1.8 Department of H Important: If its any injury or of once.		21. Signature 21. Signature 22.	2. Name and Address of Facility			
_				Lemmon Funeral Hom 10 W. Padonia Rd.,			
	MG		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final		r respiratory arrest	t,	Approximate Interval Between Onset and Death
	Priysician/ Medical	5	disease or condition resulting in death) a. Due to (or as a consequence f):	Denonter			ifens
	Examiner						
	n #	ine	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ecuter and -trans	xan	Cause (Disease or injury that initiated events resulting in death) Last				
5	be ex sician buria	dical Examiner					
09/90	ificate ig phy: as the		0.				
ŏ ×	h cert tendin r use	an/l	IF FEMALE: 23b. Was decedent pregnant In the past 12 mopths? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of del	,
POX	e deat the at hed fo	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day Year
ν. Ο	hat the		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S.	uires t n sign uld be	Completed by	Creliovascular Disease, CAD, CHF	, Hm,	1 🗆 Yes	2 No 3 Pr	obably 4 Unknown
Records,	aw rec as bee 2 sho	plet	GERD, DID		24a. Was an autopsy		opsy findings available
Ď L	The la	Sol			performe	ed? death?	2 40
N Ed	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check			
>	Phys	은	1 Inpatient 2 ER/Outpatien 27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 □ DOA 4 LU Nursing Hor	me 5 Residence 28d. Describe how	ce 6 Other (Speci	fy)
=	ath. r: Afte	icat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 □ Yes 2 □ No	ed. Describe now	injury occurred	
VISIOII OI	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
5	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.						
	e Hos 24 hc e Fun	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death of (Check only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death of the best of my knowl	igation, in my opinion, death occurred at	the time, date and	place, and due to the o	ause(s) and manner stated.
	To th within To th		29b. Signature and title of certifier	29c. License number		d. Date signed (Month	, Day, Year)
			X, T. Julita ms.	DZIY6X		5/22/12	-
Ì	4/ 1		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)	7111		
	Stat	e	REBURT LIBURIO M. 3703 & aut 57 31. Date filed (Month, Day, Year) 32. 17 gistra's Signature	paul pri	2123	y	
	Registra	_	MAY 2 4 2012 Same B.	alle			

				Pleas	e Type or										ble.		
		4	For State		State of	f Marylan					d Mer	ntal Hy	/giene	9	0.1	^	
			Registrar 1. Decedent's Name	e (First Middle	aetl		Cei	rtifica	te of L	Jeatn	2	Date of De	Reg. N	0.		2 Tm	e of Death
	Physicia		William	o (i 1701, 11110070, 2				CO	RONEI			Month 22		1 2	Year	4:55	
	Medic Examin		4a. Facility Name (if	not institution, g	ive street and num	ber)		1		Location of D	eath			c. County			
market and			Montgome 1 5. Social Security No				and to be to the color of		kvill er 1 Year		Hre To	Date of Bi		ontgo			ite or Foreign
	Funeral Director		577-46-93	396	1 M 2 □ F	7. Age (In yrs. I 95	Yrs.	Months			vlin.	(Month, D	ay, Year)	916	Cou	intry)	te or roreign
	land f shov	ţō	10a. State	10b. County			y, Town or Lo		_								e City Limits
	Mary 28a-	ire	Maryland 10e. Street and Num		ery	N.	Potoma		ip Code				405	Citizen of W	/h-+-C		Yes 2 No
	vith th	Funeral Director	11909 C1		11 Road				0878				U.S		mat Co	usiu y :	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Marr 3 Widowed	ied 2 🗆 Marrie	12. Was Deced Armed For 1 Yes If Yes, Give	2 🔼 No e		If Yes, spe	ecify Cuba	ispanic Origini n, Mexican, Pi Specify:	? (Specify uerto Rica Peruv	an, etc.)	-		k, White	ican Indiar , etc. ite	1,
8	hours natura ical E	lete		15. Decedent's		tes.	16a. Dece	dent's Us	ual Occup	ation		/ Laii	16b.	Kind of Bu		_	
215	iin 72 l ie. han "r e Med	Completed	(Spe		Grade completed) College (1-	4 or 5+)	Ìife. E	OO NOT u	se retired)	during most of	working		Dh	notography			
121	Jygier Hygier other t	oo h	17. Father's Name (First Middle Las			Phot	togra	ipner	18. Mother's	Name (Fi	rst Middle				У	
auc	be file ental l rked o ic eve	2	Victor C		9					Eufemi				, our marie,	,		
Maryland 21215-0036	12 should lith and M 27 is mar		19a. Informant's Na Nancy A.	•		r	19b. Maili 1190	ing Addre	ss (Street	and Number o Knoll F	or Rural Ro	N. P	er, City o	or Town, S	tate, Zip	0878	
Baltimore,	of Head of Hea		20a. Method of Disp	position	☐ Removal from	20b. I	Place of Disponentery, cre	matory or	other place	ce)	Date				-	Town, Stat	
Ë	t. Page tment tant:		4 Donation	5 Other (Spe	ecify)	Mon				i, Ind. M							
Bai	permit Depar Impor any in		21. Signature of Fu	neral Service Lio	9900	м008	R6 396 30	obert	Addre Mon	Fumphre tgomery	ey Fu y Ave	nera ., R	1 Ho ockv	me/Ro ille,	ockv MD	ille, 2085	Inc. 0-2805
			23a. Part 1. Enter t shock, or lea	the disease, of court failure. List onl	omplications that c y one cause on ea	aused the deat ch line.	th. Do not en	ter the mo	de of dyin	ng, such as car	rdiac or re	spiratory a	arrest,				Between
-	Pnysician/ Medical		Immediate Cause disease or condition resulting in death)		_ a	ntia										Onset a	and Death
4	Examiner		, as a sum of		Due to (or as a conseq	uence of):										
		iner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate //	b. Due to (or as a conseq	uence of):										
	executed an and irial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	injury	C. Due to /	or as a conseq	manca of										
Q	s be exe ysician a e burial		resulting in death)	Last	d.	or as a conseq	goride oij.										
68760	ertificate be ding physici se as the bu	/Med	IF FEMALE:							400							
Box 6	death c he atten ed for u	Completed by Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months? □ No		Birth 2 🗀 Fet nant at time of	al death 3	☐ Ectopid☐ Other (су				23d. Dat Mo		Day	Year
P.O.	that the ned by the detach	y Ph	Part II. Other signi	ficant condition	s contributing to d	eath but not re	sulting in the	underlyin	g cause gi	ven in Part I.		23e. Did	tobacco	use contr	ribute to	the cause	of death?
	requires been sign should by	ted t	-									1 E	1 Yes 2 No 3 Probably 4 Unknown			I 🖾 Unknown	
COL	law rei has be e 2 sh	nple			-					-		24a. Wa aut	s an opsy formed?	l r	Were au orior to death?	topsy findi completion	ngs available of cause of
æ	nysician: The law i iis certificate has t I director, page 2 s	Õ	25. Was case refer	red to medical					oe n	dans of Dooth	(Chaste as	1 ☐ Yes	2 🔯			2 🗆 No)
/ita	Physician: this certific ral director,	To Be	examiner?		Hospital:	Inpatient 2	T FR/Outpatie	ent 3 🗍	Oth	lace of Death per:	`		sidence	6 K Othe	er (Soec	in Hos	spice
f o	ing Phys	te: 1	27. Manner of Deat	th 5 🗆 Pending	28a. Date		28b. Time of injury		28c. Injur	ry at				ury occurre			•
ion	ttendii death. tor: Ai / the fu	Certificate:	2 Accident 3 Suicide	Investiga 6 Could no	ition	of Initime. At h	eme form of	M]Yes 2□N	_		/C44	and Alexander		mi Dourto A	humbor
Division of Vital Records,	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	al Cer	4 ☐ Homicide		buildii	of Injury - At h ng, etc. (Spec <i>it</i>	ý) 				28f. Location (Street and Number or Rural Route Number, City or Town, State)				idinoei,		
	e Hospital 124 hours a e Funeral I	Medical	(Check 2	2 Medical Ex	Physician: To the b aminer: On the bas Nurse Practitioner	is of examination	on and/or inve	stigation,	in my opini	ion, death occu	urred at the	time, date	and pla	ce, and due	e to the	cause(s) an	d manner stated.
	Withir Confidence	-	29b. Signature and		77.1	4.0	<u> </u>			se number			29d. [Date signed	d (Monti	h, Day, Yea	
)		MI	Olak	mer	or c	KN		R14	43201			•	2 · Z	1	.12	
	21		30. Name and add	ress of person w Miller,	cripleted cause crip. 600	se of death (Iter	m 23a) (Type, :aster	Print) Mill	Rd.	, Rockv	ille	, MD	208	55			
	Sta Registr		31. Day (140) (1/2)			egistar's Sign						-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 5,24A M 19 MAT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARUNDEL AMME GLEN BURNIE WASHING BON MEDIZAL If Unde 8. Date of Birth (Month, Day, Year, If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours **Director** 1 🗆 M 2 💢 F is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Funeral 21113 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, traumatic event, the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify 3 ₩Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industr (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name First, Middle, Last မ FLESTA 19a. Informant's Name/Relationship yp 19b. Mailing Address (Stree Important: If item 27 is any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ MEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature MI 45149 ause of death (Item 23a) (Type, Print) 30. Name and address of person who comple JABA 301 Hos 20161 31. Date filed

State Registrar 32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Τ. Carski Month Trudi :34/21 mity 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOSEPH MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 212-28-7328 1 □ M 2 🕱 F June 14, 1929 82 Maryland Silvons 2007 and Mental Hygiene.
I amd Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show
I is marked other than "natural", or items 23a or 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800A Southerly Rd. #824 21286 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Thau Anna Schmitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Theodore Carski/ Husband 800A Southerly Rd. #824 Towson, MD. 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5-24-12 Hilltop Service Co. Towson, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. Funeral Service Lio insee 23a. Part / Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VASCULAR CEREBRAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any reconditions to immediate cause. Enter Underlying Cause (Disease or injury Examiner Que to for sels conescuence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ≠ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 VALVULAR HEART DISEASE autopsy performe Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: Other: 2 X No မ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗔 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred : After 1 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31826 11 Cane 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 7601 OSLER DRIVE TOWSON, MARYLAND 21204 LINTHICUM MAY 2 4 2012 Registrar

ELOACH

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16476 for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 May 19, A M Ann Marie Douglas-Hoye 2:15 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In yrs. last birthday) Funeral Days Hours Dec. 1919 1 🗆 M 2 🖾 F 062-24-6250 New York 92 Yrs Director Usual Residence of Decedent or 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg Montgomery 1 X Yes 2 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No þ 1 Never Married 2 Married If Yes, Give Year or Dates. WW II 1 ☐ Yes 2 K No Specify. Specify: er than "natural", the Medical Exa Completed 3 K Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas J. Douglas Ann Marie Stumph 19a. Informant's Name/Relationship (Type, Print)
Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne Barron/ Representative 765 Azalea Drive, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Mav Staten Island, New York Moravian Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850 M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examir and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by useon. Advanced demente 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

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HRabit De

H. RIBERI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

29c. License number

#04115

29d. Date signed (Month, Day, Year)

May 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2012 Month May 22 Bette W. Dudley 6:23 Α Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Min Director 235-72-3002 1 □ M 2 😾 F 64 June 4, 1947 Naryland 21215-0036 Ohio Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 🌠 No Stevenson 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. I teem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1 Funeral 21153 **USA** 1810 Greenspring Valley Road 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Divorced 4 Divorced white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Wallenhorst Mary Jean Sheratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Albert H. Dudley, III /husband 1810 Greenspring Valley Road; Stevenson, MD 21153 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp 5/24/2012 5 Other (Specify) Towson, MD 4 Donation 21. Signature of 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only ne cause on each line Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 00057347 Lywha SMA 121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles St Towsky Mo 21204 SUC. a.M. Day, Year) Registrar's Signat in State Registrar

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G928,6/15/2012, WS

State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 2012 LENORA BEVERLY ELLISON 9:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death RIDERVILLE ASSISTED LIVING PRINCE GEORGES LAUREL 5. Social Security Number 6 212-22-216 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 1 M 2 XF 83 08/10/1928 MD Usual Residence of Decedent 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGES LAUREL 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral tems 23a 13205 CLARINGTON COURT 20708 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 0 þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify Completed 3 Widowed 4 X Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 APARTMENT MANAGER REAL ESTATE marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked 2 ROSEMAN **EDWARD** GERTRUDE KRAMER 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is nany injury or other trees. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRUCE ELLISON/SON 563 LANNY COURT, MILLERSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
MIKRO KODESH BETH
ISRAEL CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 \overline{K} Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/23/2012 BALTIMORE, MD ice Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY ARTERY DISEASE 10 YEARS Medical Due to (or as a consequence of) Examiner ATHEROSCLEROSIS 10 YEARS Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Directo for as a consequence of DEMENTIA 10 YEARS ician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 XNo 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 🔲 No ☐ Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNO 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Hospital or Attending Physician: The law after death.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

d State Registrar

only one) 29b. Signature

> PASMANIK, M.D., 14205 PARK CENTER DRIVE, SUITE 202, LAUREL, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

A 0053228

29d. Date signed (Month. Dav. Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Elizabeth 1306 Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) **Director** 1 M 2 XF 87 YIRGINIA ms 23a or 28a-f show must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director BALTIMORE MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 CALLOWAY U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK "natural" Completed 3. Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION ROFESSOR 5+ Be 17. Father's Name (First, Middle, Last) しいよいのいい 18. Mother's Name (First, Middle, Maiden Surname) ၉ MARTHA COLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 SON BERNARD EDMONDS 3808 CALLOWAY AVE. BALTIMORE, WARYLAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 Durial 2 Cremation 3 Removal from State Department of Important: If any injury or 124/2012 BALTIMORRIMARY/AND 4 ☐ Donation 5 ☐ Other (Specify) > Metro Crematory 21. Signature of Funeral Service 22. Name and Address of FacilityTRE DERRICK C. SENES FIH, P.A. 4611 PARK HOTS. AVE., BALTIMORE MARVIAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ptic Shock disease or condition Medical resulting in death) **Examiner** 3-5 Na Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 4 Pregnant at time of death g Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> curran Coronan Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Alhano 24a. Was an autopsy 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 2 No 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) jan RES - 000 20 V2 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Baltimore 2. Registrar's Signature State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e Per FH G927 5/31/2012 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FRANKLIN Month HARLES Ma Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Prince George's Regional Hospita aure If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 348-22-1421 **Director** 1 X M 2 | F 82 Illinois January 12,1930 Usual Residence of Dec Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start, If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Vienna Virginia Fairfax 10e Street and Number 2017 Park Terrace Court 10f. Zip Code 10g. Citizen of What Country? U.S.A. 22180 12. Was Decedent Ever in U.S. Armed Forces? 1 ₭ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 🗌 Yes 2 ื No Specify: Yes, Give 3 Widowed 4 Divorced Year or Dates.Air Force White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Air Force Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl Franklin Estelle Hawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Maxfield (Daughter) 9986 Cape Ann Drive Columbia. Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) Glen Burnie, Maryland 5-26-2012 Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia, Maryland 21045 5555 Twin Knolls Road M0123 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sepsis Physician/ Medical resulting in death) Due to or as a consequence of **Examiner** Aspiration Pneumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director: page 2 should he detached for money than the funeral director. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rena Failure Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of Failure 24a. Was an Kespiratory autopsy performe death? 1 ☐ Yes 2 ☐ No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 55861 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdul Milnim MD Laure Regional Dusen Road 7300 Van Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g927, 05/23/2012dh
Registrar Per Mental Hygiene
Registrar Per Mental Hygiene 16481 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year GEORGE FOREMAN 13: 10 PM Medical 05 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITA SAMARITAN BALTIMORE G-00D If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Director 219-32-6075 1**X** M 2 □ F 10/08/1935 76 Maryland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Baldwin MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6712 Lewis Road 21013 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married 1 Xyes 2 No
If Yes, Give Korean
Year or Dates Conflict þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Steel Worker Crown, Cork & Seal Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Camille Abell Charles J. Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Lewis Road - Baldwin, Maryland Carol P. Foreman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 05/14/2012 | Baltimore, Maryland Signature of Funeral Service List see 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE CORONAR disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed TOWAPPROVED BY MEDICAL EXAMINER that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISTASE 1 Yes 2 No 3 Probably 4 Unknown MECHANICAL VALVE REPLACEMENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy KIDNE 2 No 2 \square No 1 Yes 25. Was case referred to medical examiner?

1 X Yes 2 100 Be 26. Place of Death (Check only one) မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier RES DOD 05/10/2012

State Registrar

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DHMH 17 Rev 06-2011

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03779 2012 16482 State of Maryland / Department of Health and Mental Hygiene Joseph Keith Fabrizio Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1919 hrs May 17, 2012 Medical Examiner Joseph Κ. Fabrizio 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County Baltimore** Franklin Square Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 218-62-4278 Country) Oct.18,1954 MD Director 57 10<mark>K M 2 F</mark> Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Baltimore MD Baltimore 28a-f show permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 5920 Meadow Road 14. Rece - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married White 1 Yes 2 XNo specify: Specify. 4 Divorced If Yes, Give Year 3 Widowed ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Post Office Mechanic Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7: 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Yuhas Carmen Fabrizio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Baltimore MD 21206 5920 Meadow Road Elaine Fabrizio /wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
Bayview Crematory 1 Burial 2 X Cremation 3 Removal from State 5/24/12 Baltimore MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Secrice Licenses 300 MAce Ace. Balto. MD Connelly Funeral Home of Essex 23a. Part. Enter the disease, or camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on Death Medical a Opioid Narcotic (Fentanyl, Oxycodone) Intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transi ician/Medical AMENDED 23a, 27.28a-f, per me, g928 6-19-12 sm X UNPENDED 23d. Date of delivery of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Physi this certificate has been signed by the att il director, page 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Š pleted 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy 2 No Com Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a, Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 X No 1 Natural unknown 5 Pending fd 5-17-12 fd 6:55 pm filled in by the 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 52 Berkshire Rd. 6 X Could not be 3 Suicide determined Found In Dwelling Baltimore.MD 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. May 18, 2012

State Registrar

COME

Assistant Medical Examiner

32. Registrar's Fignature

30. Name and address of person who completed cause of death (Item 23a)

Victor Weedn MD JD

2 4 201

31. Date filed (Month, Day, Year)

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Marylands/Personnell Bf Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 2012 Ferguson 4:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Silver Spring Silver Spring 8. Date of Birth (Month, Day, Dec 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🔽 F Washington D.C. Director 92 Yrs Dec. 1919 578-12**-**6992 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Beltsville MD Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code ь 10g. Citizen of What Country? 23a Funeral 20705 10401 45th Ave. United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married þ Yes 2XXNo 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: "natural", White Completed Year or Dates event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. 17 is marked attack marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store 11 Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clark, Sr. Streets Alice Mary Alfred Joseph or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s Health a 10401 45th Ave., Beltsville, MD Toni M. Cooksey / Niece permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 04/13/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 Steple Dolomani 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 5°MINUTES Physician/ RESPIRATORY ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 1 WEEK PNEUMONIA Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury YEARS the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-transit PARAPLEGIA ON APPROVED BY MEDI that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICAT Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Other (specify) Pregnant at time of death 1 Yes 2 No signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has b irector, page 2 sh autopsy death?
1 Yes 2 No performed? Yes 2/ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No Natural 5 Pending ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Mirse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one)

State

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Registrar

29b. Signature and title of certi;

Raman R Tuli

31. Date filed (Month, Day, Year)
NAY 2 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10810 Darnestown Rd, #202

29c. License number

60

29d. Date signed (Month, Day, Year)

Grenthersburg MD 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16484 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 02AM a 2012 Medical acility Na ne (If not institution,\give street and numbe or Location of Dear 4c. County of Death **Examiner** N/A8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) Months Hours **Director** 155-12-0084 1 □ M 2 🛣 F 90 09/25/1921 ITALY 28a-f show 10a. State 10c. City, Town or Location ural", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MONMOUTH SHREWSBURY NJ10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 49 THORNBROOKE DRIVE 07702 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceuc. Armed Forces? ¹ ☐ Yes 2 🔀 No 11, Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 Divorced Completed WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LOUIS FREDELLA GERTRUDE BEVILACQUA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau ROBERT FISCELLA/SON 2720 OLD COURT ROAD, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State CREMATION, INC 05/22/2012 4 ☐ Donation 5 ☐ Other (Specify) HAMPSTEAD, MD e of Fineral Service Liver 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 1 Yes 2 No Pregnant at time of death 5 Other (specify) the 9 Unknown signed by th P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one Be examiner? 2 10 1 🗌 Yes ည ER/Outpatient 3 DOA this (4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ieral Director: After filled in by the funer (Month, Day, Year, Natural 5 Pending injury work 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 177 2 95 MS

Registrar

DHMH 17 Rev 06-2011

State

30 Name and add

31. Date filed (Month, Day, Year,

who completed cause of death (Item 23a)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 May 5:35 PM Geraldine William Grubbs Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Frederick Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours **Dírector** 578-28-2514 1 M 2 X F 91 Nov. 8, 1920 Maryland Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21774 6534 Twin Lake Dr. U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 K No Maryland 21215-0036 72 hours after 1 Tes 2 No Specify. should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>nurses'</u> <u>aide</u> nursing homes Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Richard E. Stem/ son 6534 Twin Lake Dr. New Market, MD 21774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 5/22/2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 22. Name and Address of Facility Hartzler Funeral Home, P.A. Signature of Funeral Service Lic Mi att Libertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate WELL Dear Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or in that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Ferrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an of certifier 29d. Date signed (Month, Day, Year) 00022223 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 196TJDLIVE PREDERIUG MAUTERABOLANOM 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 12:55 PM Trimes ZO/Z Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner izabeth Kehab enter timore Baltimore city 8. Date of Birth 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🕱 F Days 1472071923 West Virginia Director 88 234-36-6125 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must he marked at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Elkridge MD Howard 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6391 Rowanberry Drive Apt. 117 21095 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No. Specify: Specify: Caucasian 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary F. Long Grover C. Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8004 Brandi Way, Severn, MD 21144 Joanne Zinnert / Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Cedar Hill Cemetery May 25, 2012 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ avt oronary disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 No has 1 ☐ Yes 2 ☐ No this certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, is 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours and To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 15 enson enue 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0424 AM George L. Garrison MARCH 2012 Medical 4a. Facility Name (if not institution, give street, and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death AGN ES HOSPi BALTIMORE N/A If Unde Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 24 Hrs. **Funeral** 5. Social Security Number 229 – 38 – 7525 **Director** 1 💢 M 2 🗆 F 02/14/1932 Virginia 80 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1X Yes 2 ☐ No N/A Baltimore MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral U.S.A. 21229 4012 Walrad St. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 Xo Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farming 2nd Grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatin emone. Virginia Boggs James Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4012 Walrad St., Balt/imore, MD 21229 Catherine Stevenson(niece) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State cemetery, crematory or other place, on-site Crematory Baltimore, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 3名書時代 Affess 哲学的wn Jr. Funeral Home 2140 N. FUlton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final "Hayaktizm" disease or condition Medical resulting in death) Examiner Squarticity list or clifts, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as the burial-transit and Due to (or as a consequence of) Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, should ARRISON, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 N 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No 27. M nner of Death Other: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division hours after death. neral Director: Ai 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifyi y Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature ar 29d. Date signed (Month, Day Year) 12012 30. Name ai person who completed cause of death (Item 23a) (Type, Print) Caton Ave, Bultimore MO Meer, MM 21229

Registrar

DHMH 17 Rev 06-2011

State

2 31. Date fled (Month, Day, Year)

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4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Roderick Harrigan Physician/ 22nd 2015 11:10 AM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columb Howara Social Security Number 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Months Davs Hours Min. South Dakota Director 473-12-4497 90 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2xx No Howard Columbia Maryland 10e. Street and Number ь 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 6336 Cedar Lane Apt 215B 21044 within 72 hours after death 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. id Mental Hygiene. marked other than "natural", or à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. If Yes, Give Year or Dates. Specify White Completed 3 Nidowed 4 Divorced Navv 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Navv Be Le sirould be filed Les around be filed Les and Mental Hy, Important: If item 27 is marked other any injury or other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henrietta Doyle John Ratrick Harrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6425 Windharp Way Columbia, Maryland 21045 (Son) John Harrigan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 5-25-2012 Signature of Euneral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No 1 Yes Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie May 23rd 2012 150870 30. Name and address of person who completed cause of death (Item/43a) (Type, Print) 10910 State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

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		-	For State Registrar	State of Mary	·	rtificate of De			Reg. No.					
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		Year	3. Time of Death			
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	Examin	er	Gilchrist Hospice	eet and number)		Columbia			4c. County	ward				
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	1	-	lace (State or Foreign			
	Director		577-28-6778 1 Usual Residence of Decedent	M 2 🏝 F	89 Yrs.	I Suy	11.00.0	April 11			ngton, DC			
	and show lat	o	10a. State 10b. County	100	c. City, Town or L	ocation				11	Od. Inside City Limits			
	Maryk 28a-f	Director	Maryland Howard		Co.I	umbia			_		1 🗌 Yes 2 🕱 No			
	vith the 23a or st be n		10e. Street and Number 7070 Cradlerock Way A	apt 303		10f. Zip Code 21 0	¥ 5		10g. Citizen of U.S		try?			
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Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates.		1 Yes 2 X No		rican, etc.)	Specify	ck, White, e				
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pu	be filed vental Hygredorked otheric event,		17. Father's Name (First, Middle, Last)			1	8. Mother's Name	,	/laiden Surnam	e)				
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Mai	2 shorth and the and 27 is retraum	- 9	19a. Informant's Name/Relationship (Type, Frances Parkins (friend)		ing Address (Street and 70 Cradlerock								
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Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Parklawn (Cemetery	5-29-		Rockville	, ,	land			
Bal	permit Depar Impor any in	1	21. Signature Funeral Service Licensee	20	2	22. Name and Address of 5555 Twin Kno		zke Funer Columbia	ral Homes a, Maryla		45			
			23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death											
	Physician/	Immediate Cause (Final disease or condition _ a PROBABLE LUM LANCER Or												
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89 x	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pr	Fetal death 3	Ectopic pregnancy				23d. Date of delivery Month Day Year				
P.O. Box	ss that the death certific igned by the attending be detached for use as	Physician/N	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 Pregnant at tim 9 Unknown	e or death 5	U Other (specify)								
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	To the Hospital or Attending Physician: The law requires that the death certif To the Abours affer death. To thin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier (Check 2 Medical Examiner only one) 3 Certifying Nurse I	: On the basis of exami	ination and/or inve	stigation, in my opinion,	death occurred at	the time, date an	nd place, and du	e to the cau	se(s) and manner stated.			
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	W		30. Name and address of person who com AWIEVE DBB 31. Date filed (Month, Day, Year)	pleted cause of death	(Item 23a) (Type, MO 63	Print)	LANE	Colum	MOIA IN	100	21044			
	Sta Registra		31. Date filed (Month, Day, Year) MAY 2 4 2012	32. Registrars S	Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylan		artment of F		and Mer		iene 2	2012	16	490
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	Funeral		5. Social Security Number 6. 577–40–1960	. Sex 1 X M 2 □ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under Hours		Date of Birth (Month, Day 117	Yeard ลูก	9. Birth Cou	nplace (State or Intry) MD	Foreign
	Director		Usual Residence of Decedent		0				į Juc	11y 2/	1930		1110	
	and show	ō	10a. State 10b. County		10c. Cit	y, Town or Lo	cation		-				10d. Inside City	/ Limits
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	death with the Maryland items 23a or 28a-f sho ner must be notified at	Ö	10e. Street and Number				10f. Zip Code			1	0g. Citizer	of What Cou		
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			1 Chr	- Lil	D		MD# 2	210693	3		MAY 2	3, 201	.2	
			30. Name and address of person wh	no completed cau	use of death (Iten	n 23a) (Type, I	Print)							
			KATHERINE B. AU				50 IRVING	STRE	EET NW	, WASH	INGTO	N,DC 2	20422/68	38
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2012 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2012 10:31 AM lamon Hartman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 86 217-20-0437 Maryland Director 12/06/1925 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Baltimore Maryland Essex the 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip-Code death with U.S.A. 2027 Sue Avenue 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced WWII "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b, Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Tile & Terrazzo Mechanic Concrete 8 18. Mother's Name (First, Middle, Maiden Surname) traumatic event. 17. Father's Name (First, Middle, Last) h and Mental H Be William Charles Hartman Edna Bell Simpson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2557 New Park Road, New Park, Pennsylvania 17352 Cynthia Funk (Daughter) item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 28,2012 Baltimore, Maryland Bayview Crematory ²² Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Six of Funeral Service Licensee Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme e Cause (Final dise or condition reulting in death) Physician Hyper Canic

Due to (or as a consequence of) Respiratory /Medical **Examiner** Meumonia CENTRICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to ror as a consequence on Flame Burns 20% TBSA The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) physician Box 68760, Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate has performed 2 🗌 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Minpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 DOA ၉ this funeral 28d. Describe how injury occurred Sustained Flame burns while 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Injury After 5 Pending investigation 1 Natural 1 ☐ Yes 2 No Parning trash N7th assoline
28f. Location (Street and Number or Rural Route Number,
City or Town, State) 2027 Sue Avenue 8:00 A ours after death.

eral Director: Af
filled in by the fu death. 2 Accident May 6,2012 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ESSEX, MD 21221 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hor To the Funer completely fi Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keema Kar, 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Dewa B. parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ Nannie Hollis 910 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City Town or Location of Death **Examiner** river hast VIRU 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number **Funeral** Months Hours Min. (Month. Dav. Year) 258-05-9212 **Director** 1 □ M 2 □X€ 94 Yrs. June11,1917 Georgia 28a-f shov 10c. City, Town or Location 10d Inside City Limits at 10a. State 10b. County Director ms 23a or 28a-f s must be notified Middle River 1 Tes 2 XNo Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 21220 10e. Street and Number Funeral 2208 Firethorn Road items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐Xio Specify: "natural". 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. other traumatic event, the 12th Hair Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Theodore Valentine Stinson Nannie Thornburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Firethorn Road Baltimore MD 21220 1 and 2 s of Health item 27 Jacquelyn Payne /daughter 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date Page 1 7 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Holly "Hill Cemetery 5/23/12 Baltimore MD 4 Donation 5 Other (Specify) Funeral Servi & Licensee 22. Name and Address of Facility 300 Mace Ave. 21. Signatur Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequendany list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown or Attending Physician: The law requires that the death Month Day Year Pregnant at time of death the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autops, performed No certificate has death? 1 ☐ Yes 2 ☐ No 1 Yes **Division of Vital** 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other 2 2 00 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniurv Natural 5 Pending 1 Yes M ☐ Accident Investigation the Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

Registrar

/DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

of person who completed cause of death (Item 23a)

-18-R

			Please Type or Print in Black In State of Maryland / Dep				7
		•	_ FOI	rtificate of De	•	Reg. No.	
H	Physicia		1. Decedent's Name (First, Middle, Last) Julia Harlinski		2. Date of De Month	2011 3. Time of Death 19 2012 11:35 P	М
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Lo	May ocation of Death	4c. County of Death	_
			Stella Maris	Timoni		Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 193–14–3302 1		If Under 24 Hrs. 8. Date of Bir Hours Min. (Month, Da	ay, Year) Country)	n
	Director		193-14-3302 Usual Residence of Decedent 1 □ M 2 🖾 F 90 Yrs.		Oct. 14	4 1921 PA	
	yfand f shoved ad at	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limit	
	e Mar r 28a- notifia	Direc	MD Baltimore Timonium 10e. Street and Number	n 10f. Zip Code		1 ☐ Yes 2 🔀 N	10
	with th	Funeral Director	2525 Pot Spring Rd. 5505	21093		USA	
	items items	Fun	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hisp	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
20	after (I", or xamir	d by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ XNo		Specify: white	
9500-91212	hours natura lical E	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	ion	16b. Kind of Business/Industry	_
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2	ed with Hygier Ither t	Be C	12 n/a Home	emaker	18. Mother's Name (First, Middle,	Own Home	
ano	be file ental P rked o ic eve	70	Alexander Losztyn	,	Joan Koclakev		
lary	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show rether tranmatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and	d Number or Rural Route Numbe	er, City or Town, State, Zip Code)	
<u>د</u> ش	and 2 lealth im 27 her to		Beborah Merror/daughter		Rd., Balto., MI		_
Baltimore, Maryland	permit. Page 1 a Department of H Important: If ite any injury or ot once.		A Bunal 2 Gremation 3 G Nemova non-State	matory or other place)		20c. Location - City or Town, State	
	artme lartme lortani injury			n Cemetery 2. Name and Address		Arlington, VA	_
ñ	Dep Imp any		Michael J. Nagle	emmon Fune: 10 W. Pado:	ral Home of Du. nia Rd., Timon:	laney Valley, Inc. ium, MD 21093	
7	Physician !		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying,	such as cardiac or respiratory at	rrest, Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate outse Enter Underlying b. Due to (or as a consequence of):				
	executed an and irial-transit	Examiner	Cause (Disease or injury that initiated events c.				
	oe exe ician a burial-	<u>a</u>	resulting in death) Last Due to (or as a consequence of):				
09/89	icate by physical properties of the leading to the	ledic	d				_
ROX	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 [4 ☐ Pregnant at time of death 5 [9 ☐ Unknown	Ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
7. Ö	that th ned by e detad	y Ph	Part II. Other significant conditions contributing to death but not resulting in the		n in Part I. 23e. Did	tobacco use contribute to the cause of death?	
ďs,	quires en sign ould bu	ted t	CORONARY ARTERY DIS	EASE	1 🗆	Yes 2 No 3 Probably 4 Unknow	٧n
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within £4 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Comple			24a. Was auto perf 1 ☐ Yes	ppsy prior to completion of cause of ormed? death?	e f
<u>ra</u>	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	_ Other:	e of Death (Check only one)		
> -	y Physer this eral di	e: 1	27. Manner of Death 28a. Date of injury 28b. Time of	ent 3 ∐ DOA Dof 28c. Injury a	4 Nursing Home 5 L Resi	idence 6 LJ Other (Specify) how injury occurred	
ono	ending eath. or: Afte he fun	ficat	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	M 1 ☐ Ye	es 2 🗆 No		
NISI NISI	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (City or To	Street and Number or Rural Route Number, wn, State)	
2	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death				_
	the Ho nin 24 l he Fu	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investionly one) 3 ☒ Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, e, death occurred at the	, death occurred at the time, date time, date and place, and due to	and place, and due to the cause(s) and manner stathe cause(s) and manner as stated.	ated
_	Note to the constant of the co		29b. Signature and title of certifier Our Street Preis Chris	29c. License n		29d. Date signed (Month, Day, Year)	
	,		30. Name and address of person who completed cause of death (Item 23a) (Type,		2200	05-21-2012	
10) /		JUSTINE PREIS, CRNP 2300 DULANEY		D TIMONIUM, MI	21093	_
	Sta Registra		31. Date filed (Month, Day, Year) MAY 2 4 2012 32. Egistar's Signature	arkel			

MAY 19, 2012

JULIA HARLINSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17. 2012 8:20 P M Margaret Ann Hilkert Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery <u>Suburban Hospital</u> Bethesda Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Min. (Month, Day, Year) **Director** 095-20-8393 1 ☐ M 2 🔀 F Yrs Sept 19, 1926 Usual Residence of Decedent 85 New York 28a-f shov 10b. County 10c. City, Town or Location at Director "natural", or items 23a or 28a-1 si edical Examiner must be notified 1 Yes 2 X No Chevy Chase MD Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 8100 Connecticut Avenue #1201 20815 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced Completed White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot rother traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) (unk) Ambrose McNamara Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Tyree Hilkert / Son 3440 25th St. #101 San Francisco, CA 94110 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of Important: If i any injury or conce. 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 5/23/2012 Woodbine, Maryland 21. Sign x e of Funeral Service c 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Days to for as a nonsecutive perchicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 month Dav Pregnant at time of death 5 Other (specify) signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law page 2 s prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 **1** No Other: မူ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending I Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3/17/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew M. Leonard, MD 8600 Old Georgetown Rd. Bethesda, MD 20814 Date filed (Month, Day 32. Registr State MAY 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14:44 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director 216-72-4470 1 □ M 2 🕱 F 1963 Maryland 48 Nov 4, 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Pasadena MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 United States 8426 Arbutus Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces ori Black. White, etc. 1 X Never Married 2 Married Completed by hours after 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural". 3 ☐ Widowed 4 ☐ Divorced If Yes. Give Specify: White Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည May Brasure Robert Clement Hamilton Leona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health 6524 St. Helena Ave. Dundalk, MD 21222 Jennifer Pistorio / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 5/23/2012 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Signati f Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, Hypotension disease or condition Medical resulting in death) (or as a consequence of): Examiner 10 cardial Infarction if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Year Pregnant at time of death Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an Were autopsy findings available prior to completion of cause of death? 2 No Hospital or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 🗆 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident neral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hound To the Funer completely file 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05/19/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 Orleans St Baltimore MD 21287 ELSHAZLY MOHAMED 32. Registrar's State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOCKER <u>May</u> 18 2012 11:15 A^M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3100 N. Leisure World Blvd. #410 Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Min (Month, Day, Year) Director 577-22-2556 1 🖾 M 2 🗆 F 86 Dec. 18, 1925 Pennsylvania Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified Maryland | Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3100 N. Leisure World Blvd. #410 20906 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc ò ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Ino Specify: "natural", Completed 3 Divorced 4 Divorced Specify: WWII White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Superintendent U.S. Postal Service of Mail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ٩ Levi Hocker Mary Curran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 3100 N. Leisure World Blvd. #410, Silver Spring, Maryland 20906 Dorothy W. Hocker / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) May 24, 2012 Parklawn Memorial Park Rockville, Maryland Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. E fter the quease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Caus (Fine) Onset and Death Physician/ Gall Bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the t yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) D37142 May 22, 2012 5x1 of person who completed cause of ceath (Item 23a) (Type, Print) 1355 Piccard Drive #100, Rockville, Maryland 20850 Geoffrey Coleman, M,D.

Registrar DHMH 17 Rev 06-2011

Box 68760

P.0.

Records,

Division of Vital

Registrar's Signatus and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 For State Registrar Certificate of Death 2 Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 8:15A M Physician/ Hanna, Sr. Russell Howard 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Baltimore FRANKLIN SQUARE HUSPITal Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral (Month, Day, Year) Hours 215-12-5291 1 🗶 M 2 🗆 F 89 Director Feb 3, 1923 Maryland Usual Residence of Deced 10d. Inside City Limits 10c. City, Town or Location 10a. State should be filed within 72 hours after death with the Maryland Director must be notified 1 Yes 2 X No 28a-f Parkville Baltimore MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 USA 21234 8830 Walther Blvd. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturiany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Elizabeth George W. Hanna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6218 Arkendale Rd. Alexandria, VA. 22307 Howard R. Hanna, Jr./ Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Hilltop Service Co. 1 🗌 Burial 2 🕱 Cremation 3 🗀 Removal from State 5-24-12 Towson, MD. 4 Donation 5 Other (Specify) 22. Name and Act Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 21. Signature of Fulleral Service Livenses 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final and Anterior Myocardial Infarction Ihour Interior Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Septic shock Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed LUMONI Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23d. Date of delivery 23b. Was decedent pregnant Day Month in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown pertension, Polymyalqia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Kedney Disease autopsy performed 1 Yes 2 No Yes 2 N 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) injury 1 Natural 5 Pending s after death. Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou **To the Funer** completely fil 29a. Certifier 3 29d. Date signed (Month, Day, Year) MD RES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive-Rolfmore MO 7000 Frentin Registrar's Signature State MAY 2 4 2012 Registrar

V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ mai Furman Lee Holloway 2017 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Baltimore 9. Birthplace (State or Foreign Country)
S. Carolina If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/12/1959 Age (In yrs. last birthday) **Funeral** Days Months Hours 215-74-8766 M 2 D F **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 🏿 Yes 2 🗆 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A. 3912 Liberty Heights Ave. 21207 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ō þ Baltimore, Maryland 21215-0036 1 Yes 2X No If Yes Give Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Rucker Terminal permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Holloway Lillian Briggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip $_{
m Code)}\,21207$ 19a. Informant's Name/Relationship (Type, Print) Karen Holloway (wife) 3912 Liberty Heights Ave., Baltimore, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State on-site Crematory 05/12/17 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 30sepMdd用: Frown Jr. Funeral Home PA which Ciamo 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

Hen minu... phyxiahion Immediate Cause (Final .Physician/ disease or condition Medical resulting in death) **Examiner** minute ashaintes twenty Sequentially list conditions, if at y leading to immost cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is

To the Funeral Director: After this certificate, page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Month Day Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 10 Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 2×100 ER/Outpatient 3 DOA Inpatient May er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Tyes 2 🗌 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0064963 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Checkley BALTIMORE MD han EAST UNIVERSITY PARKWAY 31. Date filed (Month, De Registrar's Signature State

Registrar

Amend Item 27 per me,g928,06/11/2012dhb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 3 per me,g927,05/29/2012dhb
State of Maryland / Department of Health and Mental Hygiene
Amend Items 27,28a-f per me,g927,05/23/2012dhb
Amend Items 27,28a-f per me,g927,05/23/2012dhb
Reg. No. for State Registrar 16499 Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2012 Physician/ Month MAY LUCY VIRGINIA 8:27a. JENKINS 13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S BOWIE BOWIE HEALTH CARE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours MARCH 10 1934 SOUTH CAROLINA 1 □ M 2 🗓 F **Director** 577-46-4774 78 Usual Residence of Deced or 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No PRINCE GEORGE'S MD BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16916 FEDERAL HILL COURT 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 by 1 Yes 2X No 1 Never Married 2 X Married 1 Yes 2 XNo Specify. BLACK "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 2+ ADMINISTRATION PRIVATE Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | 7 is marked c ည SAMUEL MOORE EVIE HOLLAND .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 16916 FEDERAL HILL COURT BOWIE, MARYLAND 20716 JOHN J. JENKINS/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 5/17/2012 LANDOVER, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ FATAL CEREBRAL ARRHYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSIVE CARDIOVASCULAR DISEASE Sequentially list conditions Examine CERTIFICATION DATE OF THE THEM EXAMINES if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury CONGESTIVE HEART FAILURE that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical DIABETES MELLITUS IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 1 ☐ Yes ∠ ± 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖁 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an -CHRONIC SUBDURAL HEMATOMA certificate has autopsy page ? performed? 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Bowle Health Cnt 1 X Yes 2 □ No Hospital: Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work s after death. March 2012 Unknown 1 Yes 2 X No Accident Subject fell. Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined XX - NATURAL within 24 hours a Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifier Certifying Nurse Prestriction on To the best of my knowledge, depth occurred at the time, date and place, and due to the name (ii) and name as stars 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D27577 MAY 15, 2012 eth (Item 23a) (Type, Print) id address of person who completed can CUMBERBATCH MD 8416 CENTRAL AVENUE LANDOVER, MARYLAND 20785 ÓPHNELL A. Year, 31. Date filed (Mor Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:50 taines 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min. Country) 220-22-2209 Director 1 □ M 2 🗗 F 88 Yrs 2/11/1924 MD Usual Residence of Deceden ir then "neturel", or items 23a or 28e-f show the Medical Excioling in ust be notified at 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 72 hours after death with the Maryland Director N/A MD Baltimore 1 Yes 2 I No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 6232 Tramore Rd. Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) 11th College (1-4 or 5+) Packer MD Glass Factory N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pege 1 end 2 should be filed tment of Health and Mental Hi tant: If item 27 is merked ott John Coates Julia Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6232 Tramore Rd. Baltimore, MD 21214 Phyllis Stanley-Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of H important: If ite eny injury or ot once, 1 Burial 2 Cremation 3 Removal from State Garrison Forest 5/29/2012 OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H-East 1101 E. 21. Signature of Funeral Service Licenses North Ave. Baltimore, MD 21202 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementis disease or condition resulting in death) yreas Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physicien and I for use es the burlal-transi or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery Day cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown pronova 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physiclen: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Spul 1 ☐ Yes 2 ☐ No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. May ner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 292012 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M MARA 5701 Clarks W N 31. Date filed (Month, Day, Year) State MAY 2 4 2012 Registrar